PROVINCIAL PROFILE OF WOMEN'S HEALTH:

UPDATED DATA ON SELECTED INDICATORS FOR WOMEN'S HEALTH IN BRITISH COLUMBIA

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UPDATED DATA ON SELECTED INDICATORS

BRITISH COLUMBIA
Ministry of Health Services
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TABLE OF CONTENTS

List of Graphs i

Preface iii

Introduction 1

Goal One 4
Positive and Supportive Living and Working Conditions

Goal Two 8
Individual Capacities, Skills and Choices

Goal Four 14
Effective and Efficient Health Service System
That Provides Equitable Access to Appropriate Services

Goal Five 21
Improved Health for Aboriginal Peoples

Goal Six 30
Reduction of Preventable Illness, Injuries,
Disabilities and Premature Deaths

Conclusion 47

Appendix A 48

Appendix B 49

LIST OF GRAPHS

INTRODUCTION

Graph 1: Life Expectancy in British Columbia by Gender and Health Authority, 1996 to 2000 3

GOAL 1

Graph 2: Percentage of People with Low Incomes by Gender and Health Area, 1996 Census Data 5

Graph 3: Percentage of People Age 65 & Over with Low Incomes by Gender and Health Area, 1996 Census Data 6

Graph 4: Percentage of People Receiving Basic B.C. Benefits, by Gender and Health Authority, Sept. 2000 7

GOAL 2

Graph 5: Teenage Pregnancy Rates, Ages 15 to 19, per 1,000 Women by Health Authority, 1998/1999 9

Graph 6: Teenage Pregnancy Rate, Ages 15 to 19, per 1,000 Women, for British Columbia, 1990/1991 to 1998/1999 10

Graph 7: Abortion Rate per 1,000 Women, Ages 15 to 44 by Health Authority, 1999 13

GOAL 4

Graph 8: Percentage of Women Who Have Utilized Abortion Services Within Their Health Authority, 1999/2000 15

Graph 9: Age Standardized Hysterectomy Rates per 1,000 Women, Aged 20+ by Health Authority 1999/2000 17

Graph 10: Caesarean Section Births per 100 Live Births by Health Authority, 1999 18

Graph 11: Average Rates of Pap Smear Tests with the Cervical Cancer Screening Program, per 1,000 Women, Age 15 and Over by Health Authority, July 1997 – Dec. 1999 19

Graph 12: Participation Rate Percentage, Age 50 - 79, for the Screening Mammography Program of B.C. by Health Authority, 1998 to 1999, 24-month period 20

GOAL 5

Graph 13: Status Indian Life Expectancy in British Columbia, by Gender and Health Authority, 1995 - 1999 22

Graph 14: Status Indian and Other B.C. Women Premature Birth Rates per 1,000 Women by Health Authority, 1999 23

Graph 15: Status Indian Teenage Mother Rate, Below Age 20, per 1,000 Women by Health Authority, 1999 24

Graph 16: Status Indian Caesarean Section Births per 100 Live Births by Health Authority, 1999 25

Graph 17: Status Indian Age Standardized Female Mortality from Coronary Heart Disease, Rates per 10,000 Women by Health Authority, 1991-1999 26

Graph 18: Status Indian Age Standardized Female Mortality from Lung Cancer, Rates per 10,000 Women by Health Authority, 1991-1999 27

Graph 19: Status Indian Age Standardized Female Mortality from Breast Cancer, Rates per 10,000 Women by Health Authority, 1991-1999 28

Graph 20: Status Indian Age Standardized Female Mortality from Cervical Cancer, Rates per 10,000 Women by Health Authority, 1991-1999 29

GOAL 6

Graph 21: Total Sex Offences Reported to Police, Rates per 1,000 Total Population by Health Authority, 1999 32

Graph 22: Spousal Assaults Reported to Police, Rates per 1,000 Total Population by Health Authority, Annual Average, 1997-1999 33

Graph 23: Age Standardized Female Mortality from Coronary Heart Disease, Rates per 10,000 Women by Health Authority, 1999 35

Graph 24: Age Standardized Female Mortality from Lung Cancer, Rates per 10,000 Women by Health Authority, 1999 37

Graph 25: Age Standardized Female Mortality from Breast Cancer, Rates per 10,000 Women by Health Authority, 1999 38

Graph 26: Hospitalizations Due to Hip Fractures, Rates per 1,000, Age 65 and Older by Gender and Health Authority, 1999/2000 40

Graph 27: Female Populations Testing Newly Positive for HIV by Year, B.C., 1995 to 2000 42

Graph 28: New Notifications of Chlamydia (STD), Rates per 10,000 by Gender and Health Authority, 1998 44

Graph 29: Potential Years of Life Lost from All Causes of Death, Standardized Rates per 1,000 Standard Population for Females by Health Authority, 1999 46

PREFACE

The *Provincial Profile of Women's Health 2001: Updated Data on Selected Health Indicators for Women's Health in British Columbia*, contains the most recent data on selected women's health indicators. This update is a revision of the June 2000 edition. The indicators selected reflect those identified as most relevant to women and women's health, as well as those for which the data was available.

The ongoing development and publication of these profiles on women's health is one of many initiatives of the Women's Health Bureau to support health authorities in planning for women's health and monitoring services in their local health authority areas. Another example of such an initiative is the document *Health Goals for British Columbia Women (2000). Health Goals* is an innovative work that applies the six generic provincial health goals that were developed after extensive consultation and approved by the provincial government in July 1997, to women's health. *Health Goals* provides objectives, indicators and strategies that can be used to assist health authorities with setting targets and developing initiatives to address and enhance women's health. The *Profile of Women's Health and Health Goals* are resources that may be used in conjunction with one another or independently.

Health authorities and health planners are encouraged to augment the data provided here with demographic profiles specific to their geographical populations and the women's health issues relevant in those specific populations.

For copies of these documents, information on gender-inclusive health planning or women's health issues, please contact the Women's Health Bureau at (250) 952-2256 in Victoria. Outside of Victoria, call Enquiry B.C. at (604) 660-2421 in Vancouver or 1-800-663-7867 elsewhere in the province, and ask to be connected to the Women's Health Bureau.

INTRODUCTION

In December 1997, the British Columbia Ministry of Health Services[1] published *Health Goals for British Columbia*, a document containing six goals which

> *Set out a vision and means for improving the health of the population and reducing health inequities by increasing awareness and understanding of the factors that truly affect our health, and by providing a framework that will enable people to work towards realizing that vision. Health goals are a powerful tool for identifying health priorities and for linking policies and investments to these priorities.*

In this document, *Provincial Profile of Women's Health 2001: Updated Data on Selected Health Indicators for Women's Health in British Columbia*, the health goals and their corresponding objectives are used as a framework for providing women's health information. The primary purpose of this document is to assist health planners and health authorities in prioritizing women's health needs and to incorporate these issues into policy, program planning, and resource allocation. Quantitative data is provided on selected indicators for five of the six health goals, as well data on an overall indicator — life expectancy. New indicators in this update include:

- Low income rates age 65 and over;
- Pap smear test rates;
- Participation rates for the screening mammography program of B.C.;
- Hospitalizations due to hip fractures;
- Female persons testing positive for HIV; and
- Rates of new notifications of chlamydia

In addition, this is the first time Aboriginal women's health indicators are being included in this report. These indictors include:

- Life expectancy
- Premature birth rates
- Caesarean section rates
- Teenage mother rates
- Coronary heart disease mortality
- Lung cancer mortality
- Breast cancer mortality
- Cervical cancer mortality

In addition, qualitative information is used to place the statistical information in the context of women's lives.

The indicators for which data is provided are not intended to be an exhaustive inventory of women's health issues. Rather, they are selected as examples to provide an overview of the diversity of women's health issues. The particular indicators are selected for the following reasons: they are relevant to women's health; health authorities and planners have expressed interest in these indicators; and, quantitative data exists and will likely continue being collected to allow for comparison across time.

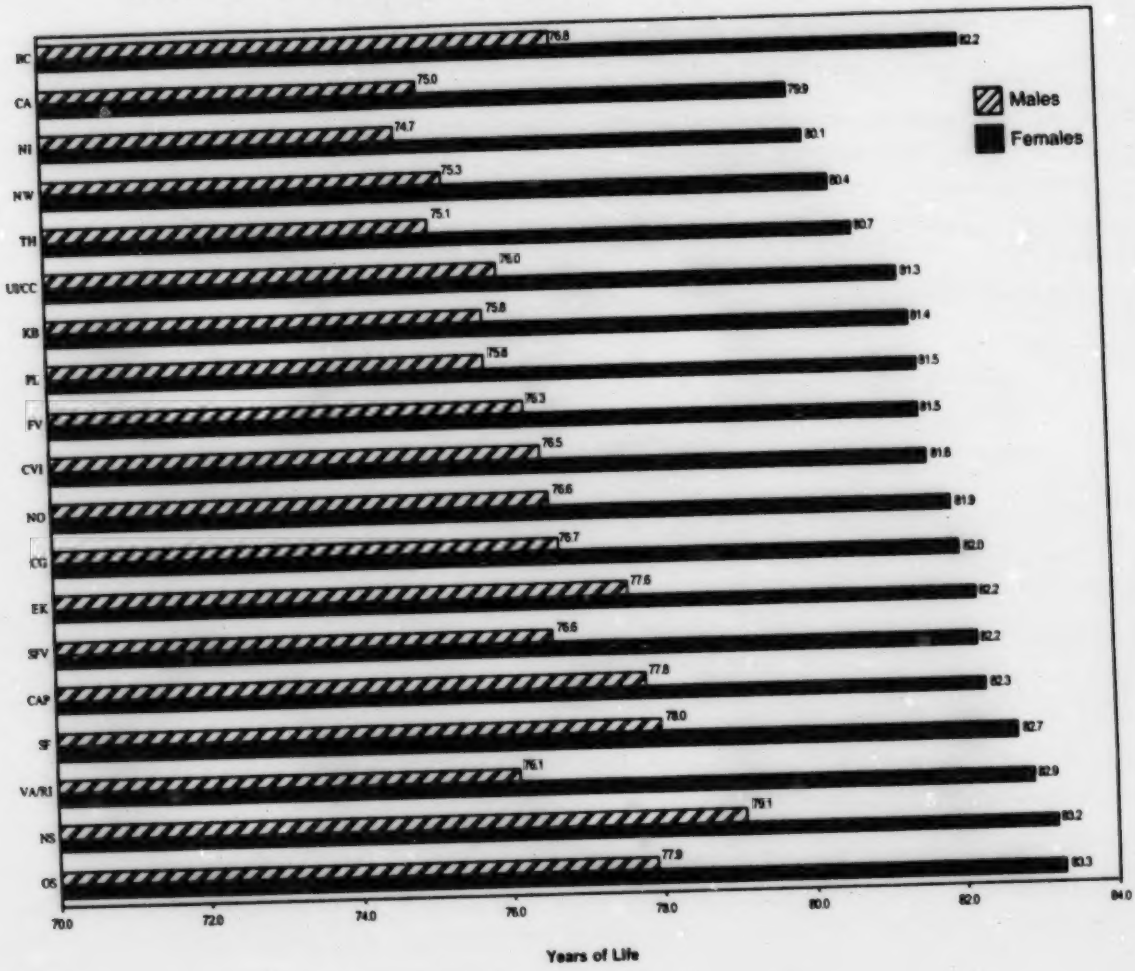
The indicators were selected to address a broad definition of health and are consistent with the population health approach. Broadly defined, women's health comprises more than physical health. It includes emotional, social, cultural, and spiritual aspects and is intricately related to the social, political and economic context of women's lives. A population approach to health examines factors, such as income and social conditions that influence the health of population groups.

The population approach to health recognizes that different population groups have varied access to the factors that contribute to health and that these factors are not equally distributed. For example, socio-economic status is positively associated with health status. However, in comparison to men, women still receive less pay on average for the same work and more often live in poverty. Women are also more often victims of violence and are under-represented in decision-making bodies, compared to men. These factors are compounded by the fact that women experience more and different barriers to health care than men and, despite longer life expectancy, suffer more ill health during their life span than men. Women also use the health care system 25 per cent more often than men. Consequently, gender is regarded as one determinant of health because being male or female to some extent determines future health.

Any measure of women's health must also take into consideration the diversity of women. Women are not a homogeneous group; they often have very different experiences of health, illness and health care, and have different access to the conditions that contribute to health and well-being. For example, according to data on life expectancy (Graph 1), B.C. women enjoy a standard of health that is among the best in the world. However, not all groups of B.C. women enjoy this same standard. For example, women in urban areas live four years longer, on average, than women in rural and northern areas. Also, Aboriginal women have an average life expectancy seven years less than that of non-Aboriginal women.

While quantitative data provides useful information for planning and monitoring, it must be viewed in the appropriate context. Qualitative data sources, such as local women serving organizations, also contribute valuable information on women's health issues. Health authorities and health planners are encouraged to consult other sources of data related to women's health. In addition, more detailed statistics are available through the health data warehouse. The health data warehouse has indicator links to *Provincial Health Goals.*

Graph 1: Life Expectancy in British Columbia by Gender and Health Authority, 1996 - 2000



Source: B.C .Vital Statistics, B.C. Ministry of Health
Population information provided by : B.C. STATS & B.C. Ministry of Finance & Corporate Relations
Data provided by: Health Data Warehouse, B.C. Ministry of Health
Prepared by: Women's Health Bureau, B.C. Ministry of Health

GOAL ONE: POSITIVE AND SUPPORTIVE LIVING AND WORKING CONDITIONS

Poverty and Health

Poverty is associated with a number of conditions that adversely affect health and limit access to health care, including poor housing conditions, behavioral problems, isolation and depression. Research has found that people who are living in conditions of lower socio-economic status as measured by income, education or occupational status are more likely to:

- experience disease, disability and early death;
- work in dangerous, stressful or unstable jobs;
- live in unsafe or unhealthy homes and neighborhoods and spend relatively high proportions of their income on housing that may be temporary; and,
- have less social support and fewer social networks.

These conditions in turn are associated with an increased risk of disease as a result of high blood pressure, high cholesterol levels and the release of stress hormones. Persons who are socially isolated are at greater risk of disease.

People living in poverty are also more likely to:

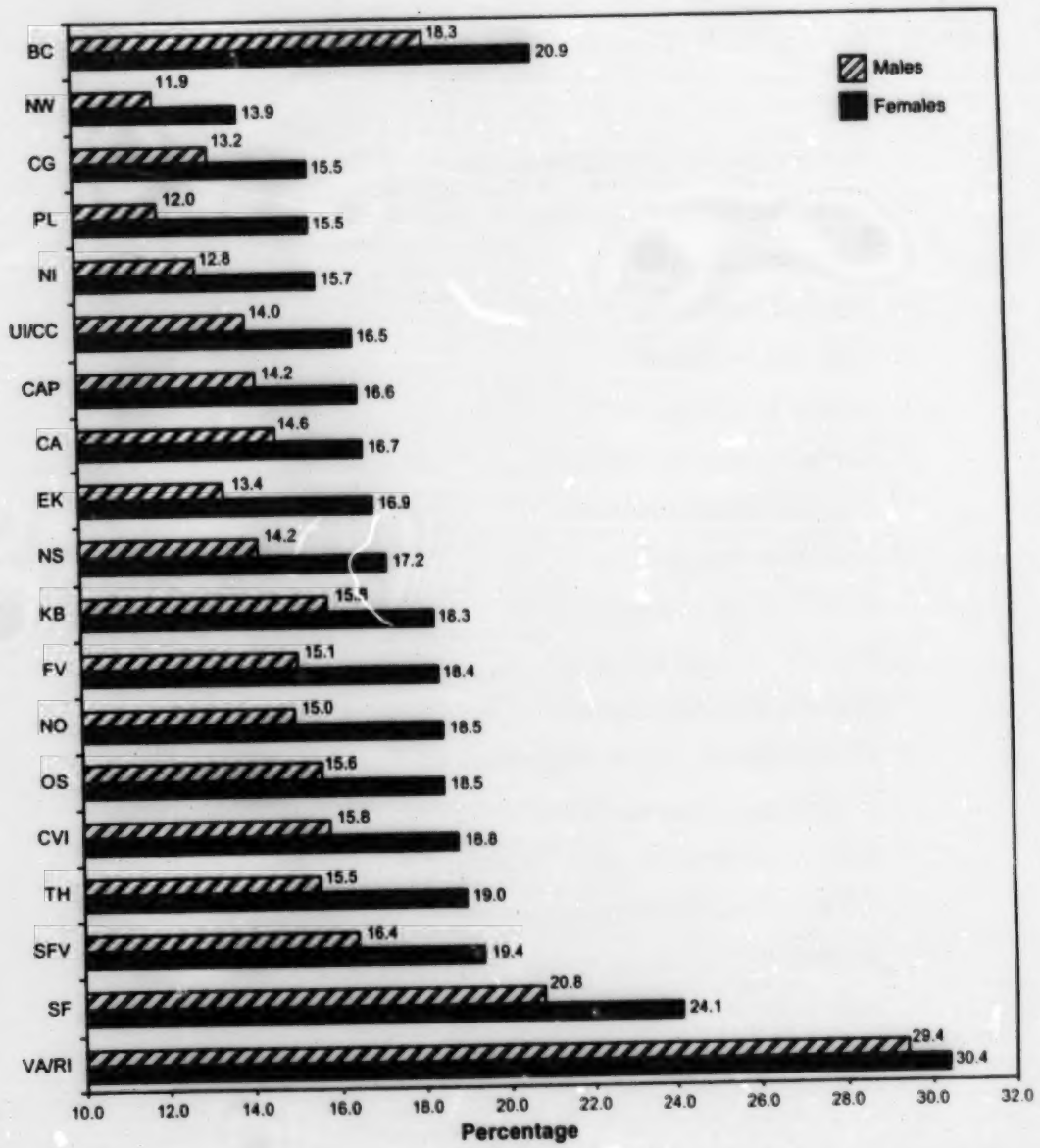
- engage in health damaging behaviors, such as smoking or substance abuse; and,
- experience obstacles to obtaining basic health care services, such as lack of transportation, difficulty in arranging child care or time off work to attend appointments and the expense of medication.

Given the multiple effects of poverty, it is not surprising that it is also associated with poor health status. Certain population groups, such as women and seniors, are more susceptible to poverty and their health is also differently impacted.

Low Income

Employed women working full-time, year-round in B.C. earn 73 per cent of what men earn. Women are also more likely to work part-time due to childbearing and other care giving responsibilities. A person or family is considered to be below the low income cut off (LICO) if 70 per cent of their income is used to buy food, clothing and shelter. In every region of B.C., more women than men fall below the Statistics Canada LICO, which for a single adult was at or below $11,407 (after tax) annual income in 1998.

Graph 2: Percentage of People with Low Incomes by Gender and Health Area, 1996 Census Data

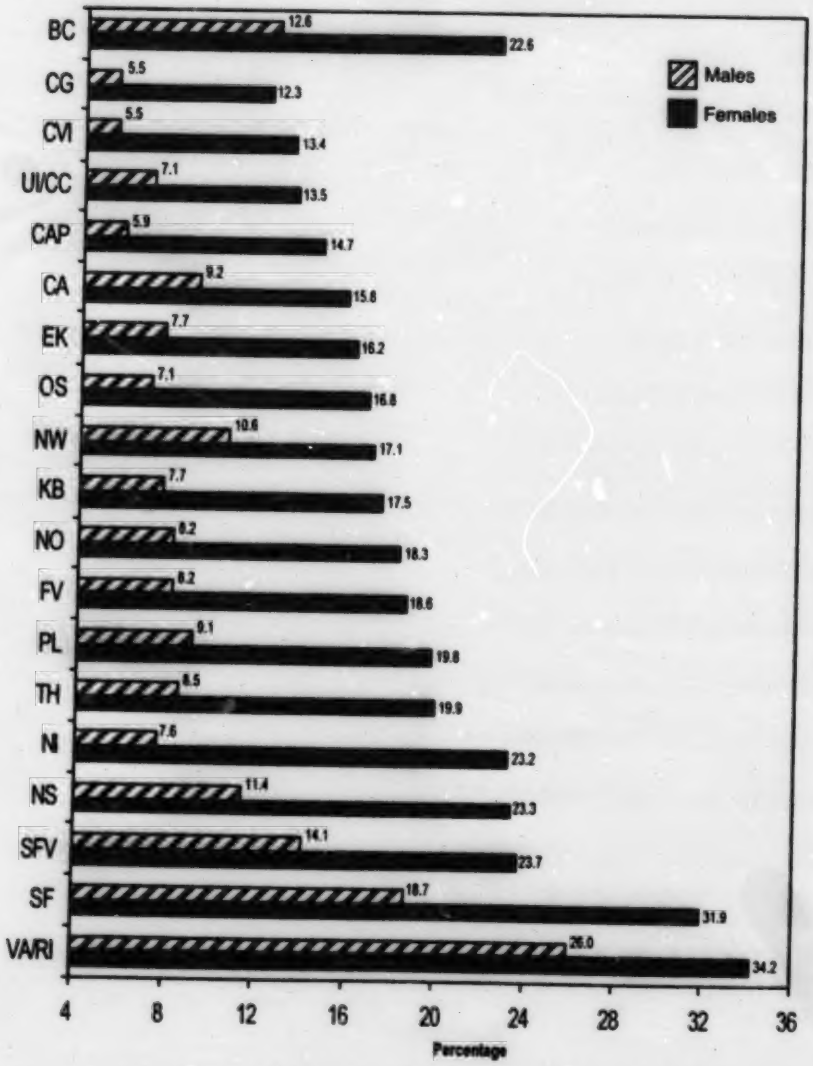


Source: Statistics Canada, 1996 Census of Canada, custom tabulation GO0199, 20 % Sample Data, Statistics Canada
Data provided by: Health Data Warehouse, B.C. Ministry of Health
Prepared by: Women's Health Bureau, B.C. Ministry of Health

Low Income - Seniors

Many women in British Columbia aged 65 and over are also living in poverty. In 1996, it was estimated that one in four senior women were living below the LICO, more than double the rate for senior men. A woman or man receiving the maximum: Old age pension ($436.55/month), guaranteed income supplement ($518.82/month) and seniors' supplement ($49.30/month) in April of 2001, would receive a total sum of $1004.67 monthly if they were to have very little or no additional income. The number of senior women living in poverty has risen, and may continue to do so in the future as seniors are becoming a considerably larger portion of the population. Women comprise a higher percentage of the senior population and tend to live significantly longer than men.

Graph 3: Percentage of People Age 65 & Over with Low Incomes by Gender and Health Area, 1996 Census Data



Source: Statistics Canada, 1996 Census of Canada, custom tabulation GO0199, 20 % Sample Data, Statistics Canada
Data provided by: Health Data Warehouse, B.C. Ministry of Health
Prepared by: Women's Health Bureau, B.C. Ministry of Health

Income Assistance

As a consequence of higher levels of poverty among women, more women, both young and old require income assistance to maintain a minimal standard of living. With the exception of the Vancouver/Richmond and Capital Health Regions, more women than men between the ages of 19 and 64 receive income assistance from the provincial government. In June 2001, a single woman or man receiving basic B.C. benefits would be given a maximum of $510 monthly and a lone-parent family would receive a maximum of $896.58 monthly.

The relationship between poverty and health is complex due to the many and varied socio-economic problems related to poverty. The links between the social and economic environment are particularly important for women who have lower incomes on average and receive income assistance more often. The stress of living in poverty and receiving income assistance can affect physical and mental health, access to health care, nutrition and other lifestyle factors for women and their families. Health authorities should be aware of these factors and effects as they plan to address the health needs of designated populations.

Graph 4: Percentage of People Receiving Basic B.C. Benefits, Age 19 to 24, by Gender and Health Authority, September 2000

Source: Ministry of Social Development & Economic Security administrative files & B.C. STATS population estimates
Population information provided by: B.C. STATS & B.C. Ministry of Finance & Corporate Relations
Data provided by: Health Data Warehouse, B.C. Ministry of Health
Prepared by: Women's Health Bureau, B.C. Ministry of Health

GOAL TWO: INDIVIDUAL CAPACITIES, SKILLS AND CHOICES

Reproductive Health

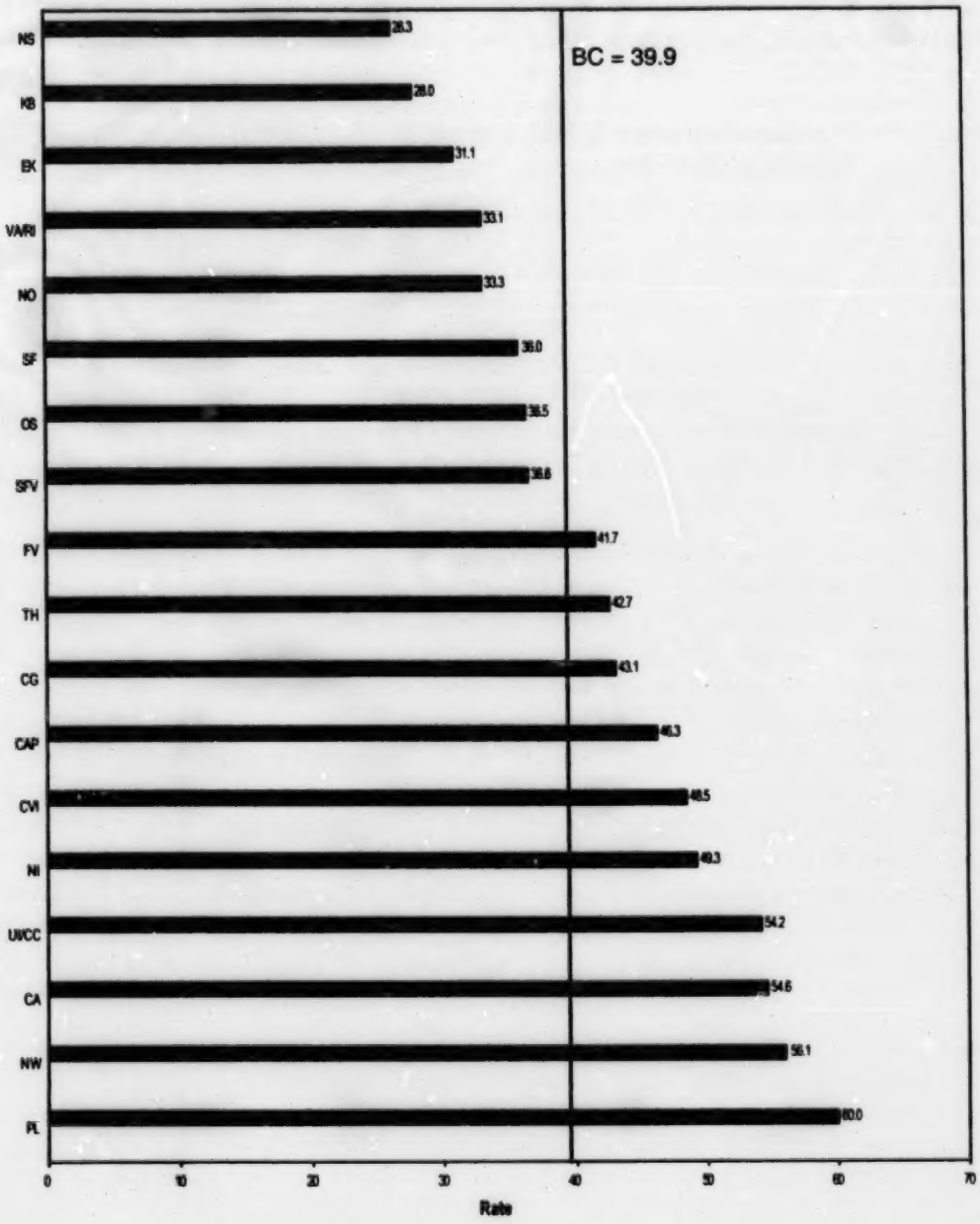
Reproductive and sexual health is one area where it is imperative that women have access to unbiased information to develop capacities and skills for making informed choices. Comprehensive reproductive health recognizes that women across their life span have special needs and rights in relation to reproduction and sexuality. For example, teens need information about issues such as sexuality, sexually transmitted diseases and unintended pregnancy; women in their child-bearing years need information about fertility and childbearing; and, women in mid-life and beyond need information about the natural changes and impacts on sexuality that occur throughout the aging process.

Teenage Pregnancy

For teens, information on safe sex practices is an important component of prevention against unintended pregnancy. Early teenage childbearing is of particular concern, often beginning a cycle of poverty and dependence on social assistance. In addition, birth outcomes are generally poorer when the mother is a teen. Babies born to teenage mothers usually have lower birth weights and are more susceptible to illness and Sudden Infant Death Syndrome. Because many teen pregnancies are unintended and birth outcomes are generally poorer among teen mothers, it is important that reducing teen pregnancy rates be a priority.

Methods to accomplish this include sex education and better access to contraceptive clinics. The myth still persists that sex education leads to promiscuity; however, the opposite has proven true. It has been repeatedly shown that sex education leads to responsible behavior, higher levels of abstinence, later initiation of sexuality, more frequent use of contraception and fewer sex partners. A combination of reproductive health education and the availability of contraceptive clinics can substantially reduce teen pregnancy, unwanted births and abortions.

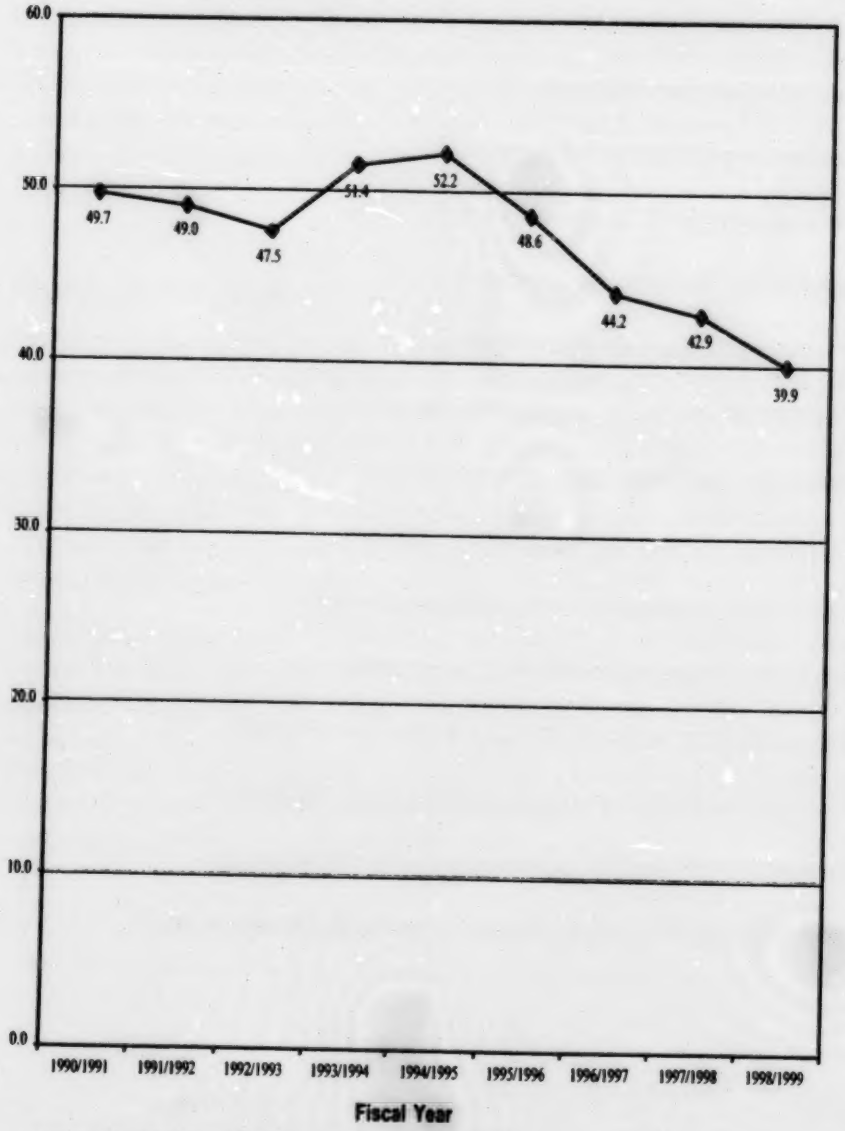
Graph 5: Teenage Pregnancy Rates*, Ages 15 to 19, per 1,000 Women by Health Authority, 1998/1999



Source: B.C. Vital Statistics Agency, B.C. Ministry of Health
Population information provided by : B.C. STATS & B.C. Ministry of Finance & Corporate Relations
Data provided by: Health Data Warehouse, B.C. Ministry of Health
Prepared by: Women's Health Bureau, B.C. Ministry of Health
*Teenage pregnancy rates include live births, still births, induced abortions, and miscarriages resulting in hospitalization.

Teenage pregnancy rates in B.C. have been gradually decreasing — from 49.7 per 1,000 females in 1990/91, to 39.9 per 1,000 females in 1998/99. This declining trend can be seen in most of the health authority areas. However, the decrease is less evident in a few of the health areas, including South Fraser, Peace Liard, North Shore, Capital and the Cariboo.

Graph 6: Teenage Pregnancy Rates*, Ages 15 to 19, for British Columbia, 1990/91 to 1998/99



Source: B.C. Vital Statistics Agency, B.C. Ministry of Health
Population information provided by: B.C. STATS & B.C. Ministry of Finance & Corporate Relations
Data provided by: Health Data Warehouse, B.C. Ministry of Health
Prepared by: Women's Health Bureau, B.C. Ministry of Health
*Note: Pregnancy rates per 1,000 females ages 15-19. Pregnancies include live births, still births, induced abortions and miscarriages resulting in hospitalizations. Multiple births are counted as one pregnancy. The apparent increase in rates in 1993 reflects the inclusion of data on therapeutic abortions performed in freestanding clinics in the lower Mainland. These clinics were established in the late 1980s. Beginning with the 1993/1994 fiscal year, clinic summary data are being merged with hospital statistics in order to provide a more complete picture of pregnancy outcomes in B.C.

Emergency Contraception

Emergency contraception is a method utilized to reduce the risk of unintended pregnancy up to 72 hours after unprotected sexual intercourse or contraceptive failure. Emergency contraceptive pills (ECPs) have been in use in Canada for more than 30 years and are a high dose of regular oral contraceptives taken in two doses twelve hours apart. ECPs act in the same way as regularly taken oral contraceptives to prevent ovulation, penetration of the egg by the sperm and implantation of a fertilized egg. ECPs will not interrupt an already established pregnancy. The safety of ECPs has been well documented and the overall estimates of effectiveness are about 75 per cent for an estrogen/progestin agent (Ovral®) and about 85 per cent for levonorgestrel (Plan B™). ECPs are not intended for regular use and are not as effective as a regularly used birth control method, which has been shown to be more than 95 per cent effective at preventing unwanted pregnancies.

On December 1, 2000, trained certified pharmacists in British Columbia were given the authority to provide ECPs to women without a doctor's prescription. Because the effectiveness of ECPs is time dependent, expanding access through community pharmacies will help women at risk of an unwanted pregnancy to obtain ECP therapy in a timely manner.

In 1998/1999, approximately 23 per cent of all pregnancies in B.C. ended in abortion; in the age groups of 15 to19 years of age and 20 to 24 years of age, the abortion rates were 54 per cent and 34 per cent respectively. Many of these abortions could have been prevented and both the economic and psycho-social costs could have been alleviated had ECPs been utilized. In the first six months of the expanded access program, pharmacists in more than 400 different pharmacies in all 20 health regions in the province have initiated nearly 3,000 ECP prescriptions. With more than 70 per cent of pharmacist-initiated ECP use among women under 30 years of age, this preliminary data suggests that the initial uptake of the expanded access program has been effective in providing access to ECPs to those at the highest risk of unwanted pregnancy and subsequent abortion. The mean age of ECP users is 26 years of age. Almost 60 per cent of women's requests to pharmacists came on weeknights and weekends when physician's offices and many health clinics were not open. Over half of the women who requested the pills did so because their regular birth control method failed.

B.C. women can now call a toll-free telephone line (1-888-NOT-2-LATE) or access a Web site (www.not-2-late.com) to get automated information about ECPs and to receive a list of pharmacies, physicians and clinics that can provide the service in their area. It should be noted that ECPs are also available at very low cost from youth clinics and organizations such as Planned Parenthood.

By expanding awareness of the availability of ECPs, pharmacists hope to further decrease the number of unwanted pregnancies and, therefore, the number of abortions.

*Source: Collaboration for Outcomes Research and Evaluation, UBC.

*Note: In the next update, the intent is to have an ECP usage indicator by health region.

Abortion

A comprehensive approach to reproductive health is premised on women's rights to control the timing and spacing of their pregnancies, and the right to affordable, safe and accessible birth control information, products and services. This approach also supports women's right to choose whether to continue a pregnancy to term or to access abortion services without harassment.

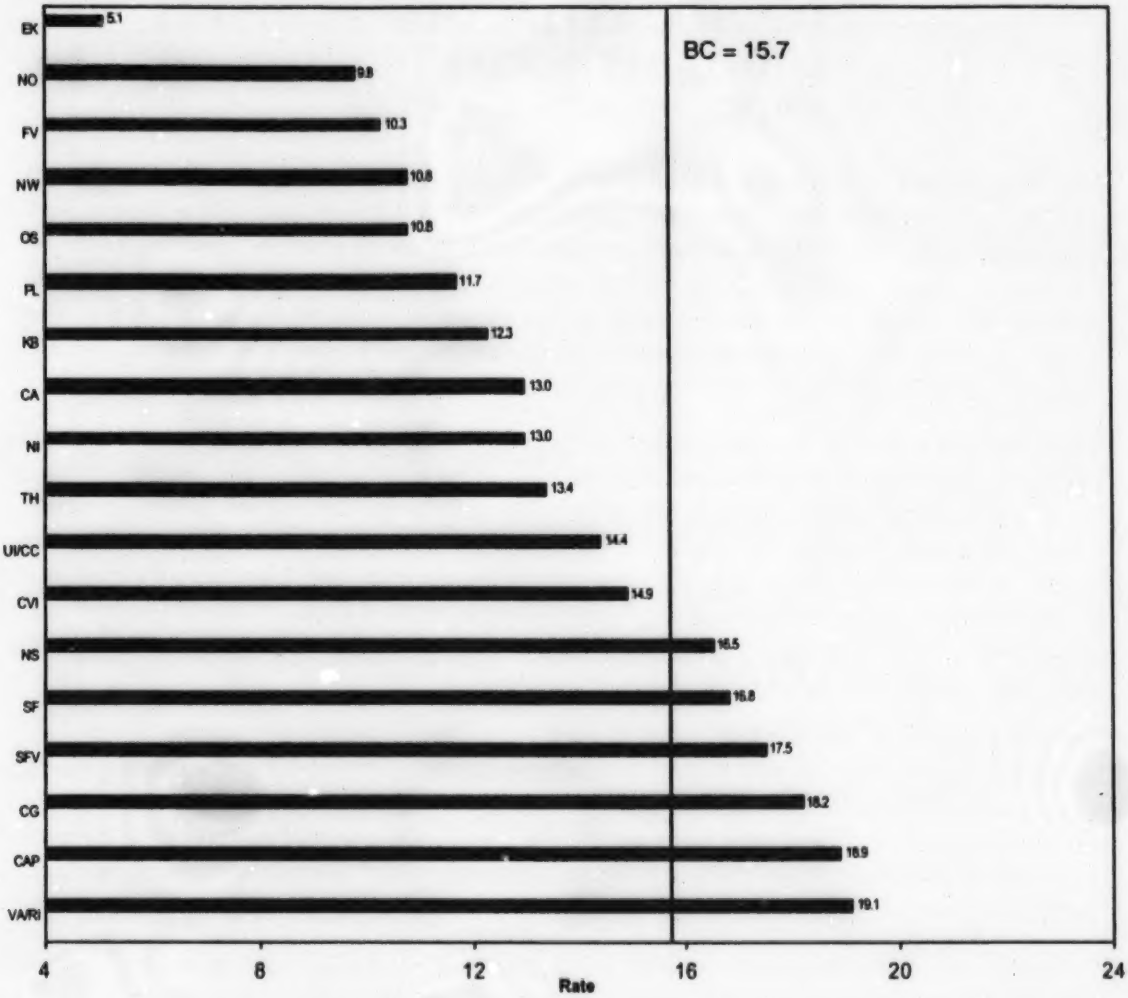
The option of not continuing a pregnancy to term:

- is consistent with B.C.'s policy that abortion is a legally and medically required service;
- supports the Supreme Court ruling that deemed unconstitutional the section of the Criminal Code that made abortion illegal; and,
- supports the Canada Health Act (1994) that embodies the principles of accessibility, universality, portability, comprehensiveness and public administration.

Abortion rates provide an indirect measure of unintended pregnancy, availability of information and access to and use of contraception. A significant number of women experience unintended pregnancies, which is indicated by the fact that approximately one in five pregnancies end in abortion. Unintended pregnancies occur at all ages, but the majority of women who have abortions are in their early twenties. Women aged 20 to 24 are three times more likely to have an abortion than women in their early to late thirties. It is important to ensure that women in B.C. are provided with the information and services to assist them in controlling their reproductive health.

It is important for the reproductive health of both women and men that people have access to the knowledge and resources which enable them to make responsible and safe decisions in regards to their sexuality and that they have the freedom to decide if, when and how often to have children (World Health Organization). By many standards, women in B.C. enjoy a high level of reproductive health. However, many women experience unintended pregnancies, sexually transmitted diseases and reproductive tract infections. While not all problems can be prevented, many can be prevented through education and access to services and products. Health planners and authorities should be aware of the barriers women face in obtaining reproductive health information and services in their communities.

Graph 7: Abortion Rate per 1,000 Women, Ages 15 to 44 by Health Authority, 1999



Source: B.C. Vital Statistics Agency, B.C. Ministry of Health
Population information provided by : B.C. STATS & B.C. Ministry of Finance & Corporate Relations
Data Provided by: Health Data Warehouse, B.C. Ministry of Health
Prepared by: Women's Health Bureau, B.C. Ministry of Health

GOAL FOUR: EFFECTIVE AND EFFICIENT HEALTH SERVICE SYSTEM THAT PROVIDES EQUITABLE ACCESS TO APPROPRIATE SERVICES

Equitable access to appropriate health services is an essential part of an effective health care system. Because women use the health care system 25 per cent more than men, it is important that services be available and appropriate to meet women's health needs. "Equitable access" and "women's health" often present a paradox. Access to some services and products is limited, notably in the area of reproductive health. On the other hand, services, products and pharmaceuticals are often over-used, resulting in inappropriate treatment or "over-medicalization" of women's health care.

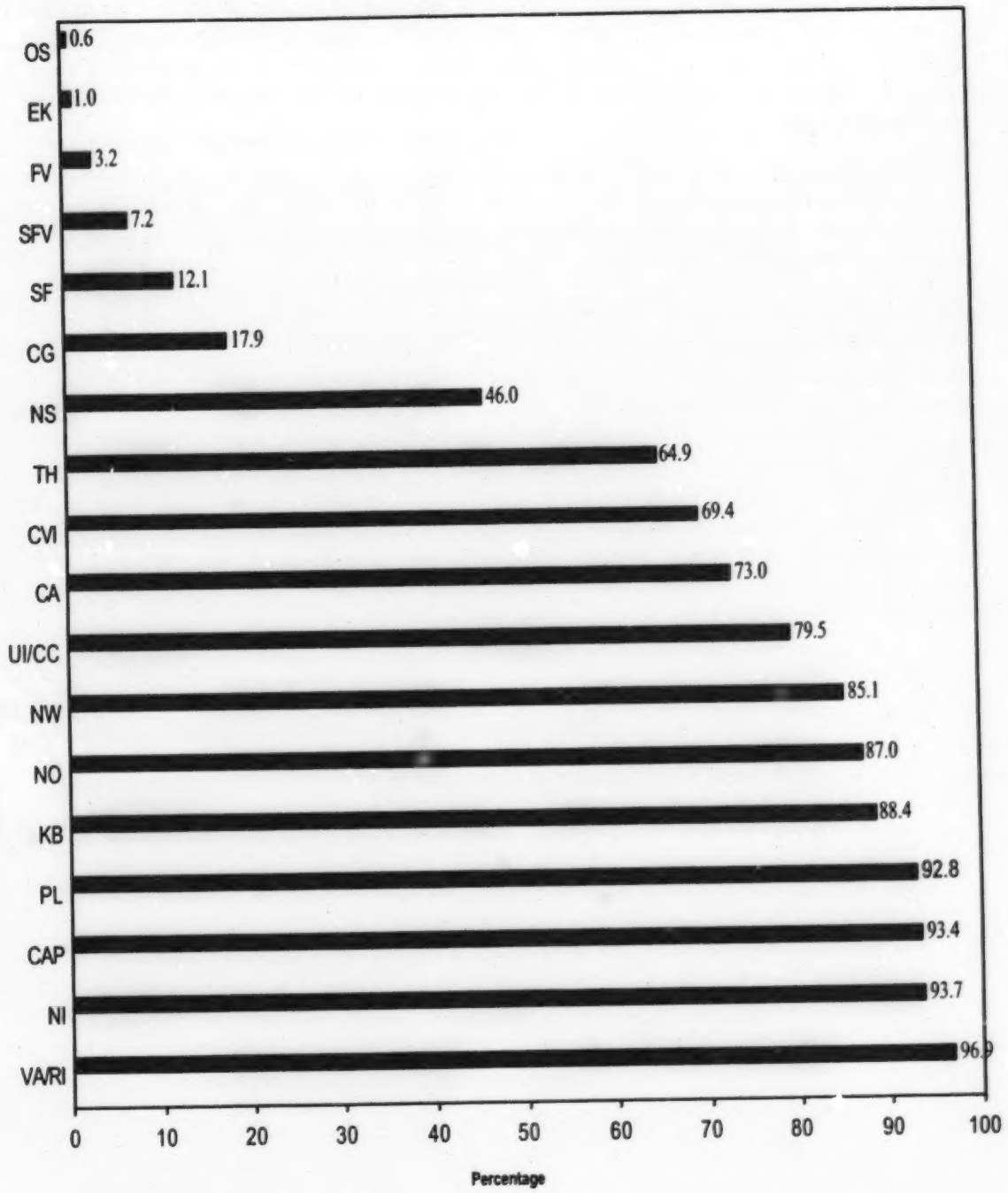
Reproductive health is one area where women face barriers to accessing legally available, medically required health services. Women should be able to obtain health care services in their own community, which is not always the case when dealing with reproductive health concerns. Abortion is an example of a service to which access and utilization vary widely across B.C. A community's ability to provide abortion services to its own residents is one indicator of accessibility. A large number of women travelling out of their residential area to receive abortion services may indicate either problems with access or a perceived or real lack of confidentiality.

The health areas encompassing the lower mainland have a low percentage of women receiving abortion services in their own community. Because services are readily available in Vancouver, these women do not face as many geographical barriers as those women living in the northern and rural parts of B.C. Nevertheless, transportation for the several required appointments and time off work are major financial barriers for many women living in these communities, particularly young women.

Although some health areas have high percentages of women receiving abortion services in their regions, this does not necessarily mean services are readily accessible and available. Due to the size and geography of some health authorities, women might have to travel long distances even within their own health area to obtain services.

In addition, some health care facilities in the province are not providing abortion services to women in their health authority area, even if they have the capacity to do so. Since abortion is considered a legally mandated service in B.C. and is a component of the health-funding envelope, abortion services must be readily available in all geographic areas of the province.

Graph 8: Percentage of Women Who Have Utilized Abortion Services Within Their Health Authority, 1999/2000



Source: Discharge Abstract Database, Information Support, Regional Programs, B.C. Ministry of Health
Prepared by: Women's Health Bureau, B.C. Ministry of Health
* Note: Includes hospitals & free-standing abortion clinics

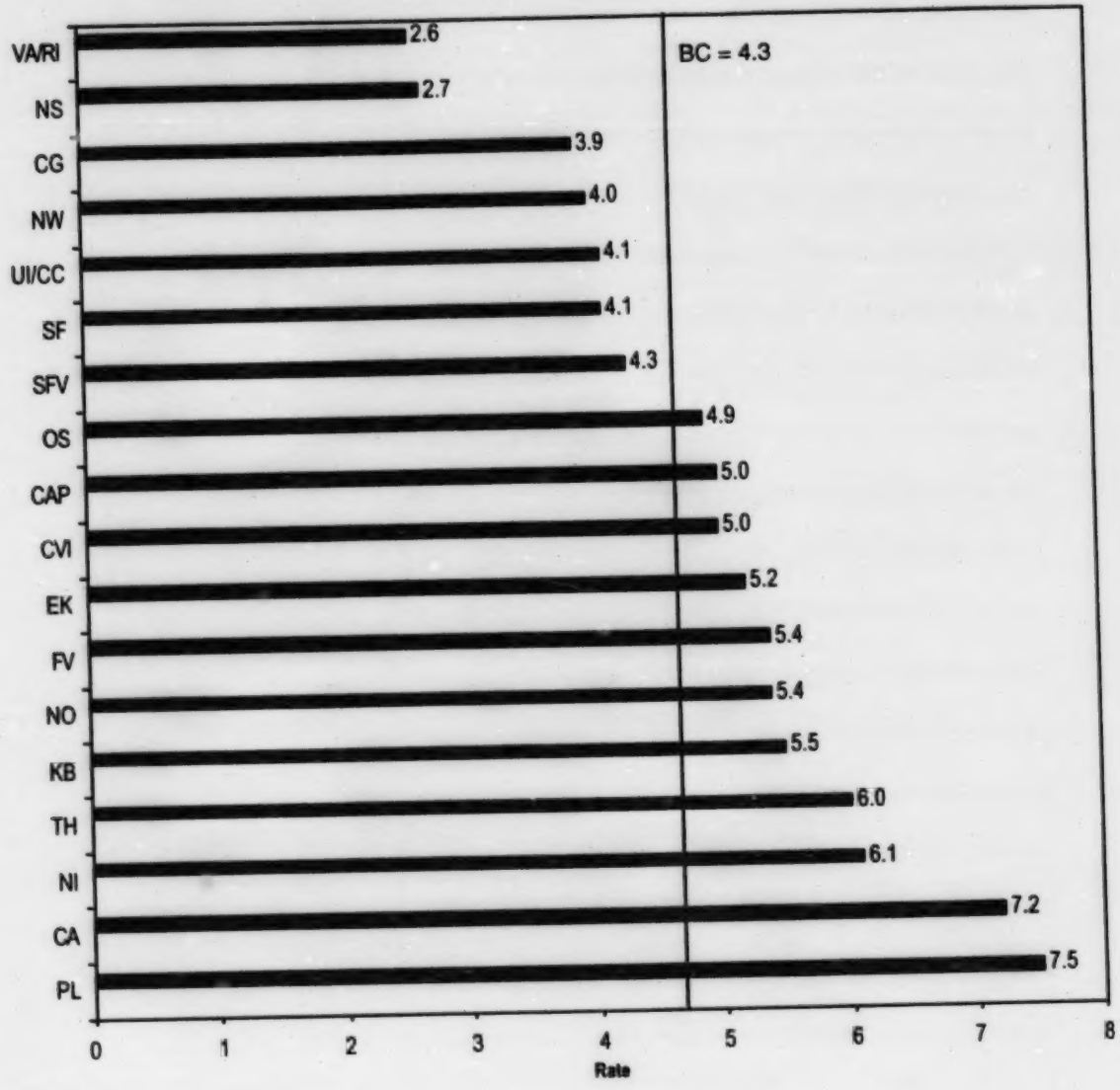
Caesarean Sections & Hysterectomies

Advocates have long been concerned that the biomedical model of health care has led to over-treatment of women with certain health concerns. The biomedical model, the dominant approach to health care in Canada today, is based on technological and pharmacological interventions focused on, but not limited to, hospitals, physicians and pharmaceuticals.

Over-medicalization of women's health refers to situations where treatment relies too heavily on highly technological interventions when a less invasive or aggressive approach would be of similar or greater benefit, and when the medical approach is applied to situations that are not "treatment" issues.

Because women use the health care system more frequently than men, women are at greater risk of receiving services that are inappropriate and unnecessary. Over-medicalization has physical, mental and emotional consequences related to both the actual procedures (tests, medications, surgeries, etc.) and to the consequences on women's lives (time away from work, lack of home support during recovery, etc.). Research has shown that medical procedures such as hysterectomies and cesarean sections are performed at higher rates in some areas than necessary. While these procedures are clearly appropriate in some cases, they should not be done unnecessarily. It is important for the health care system to provide women with the information to make informed choices about medical procedures and available alternatives.

Graph 9: Age Standardized Hysterectomy Rates per 1,000 Women, Aged 20+ by Health Authority 1999/2000



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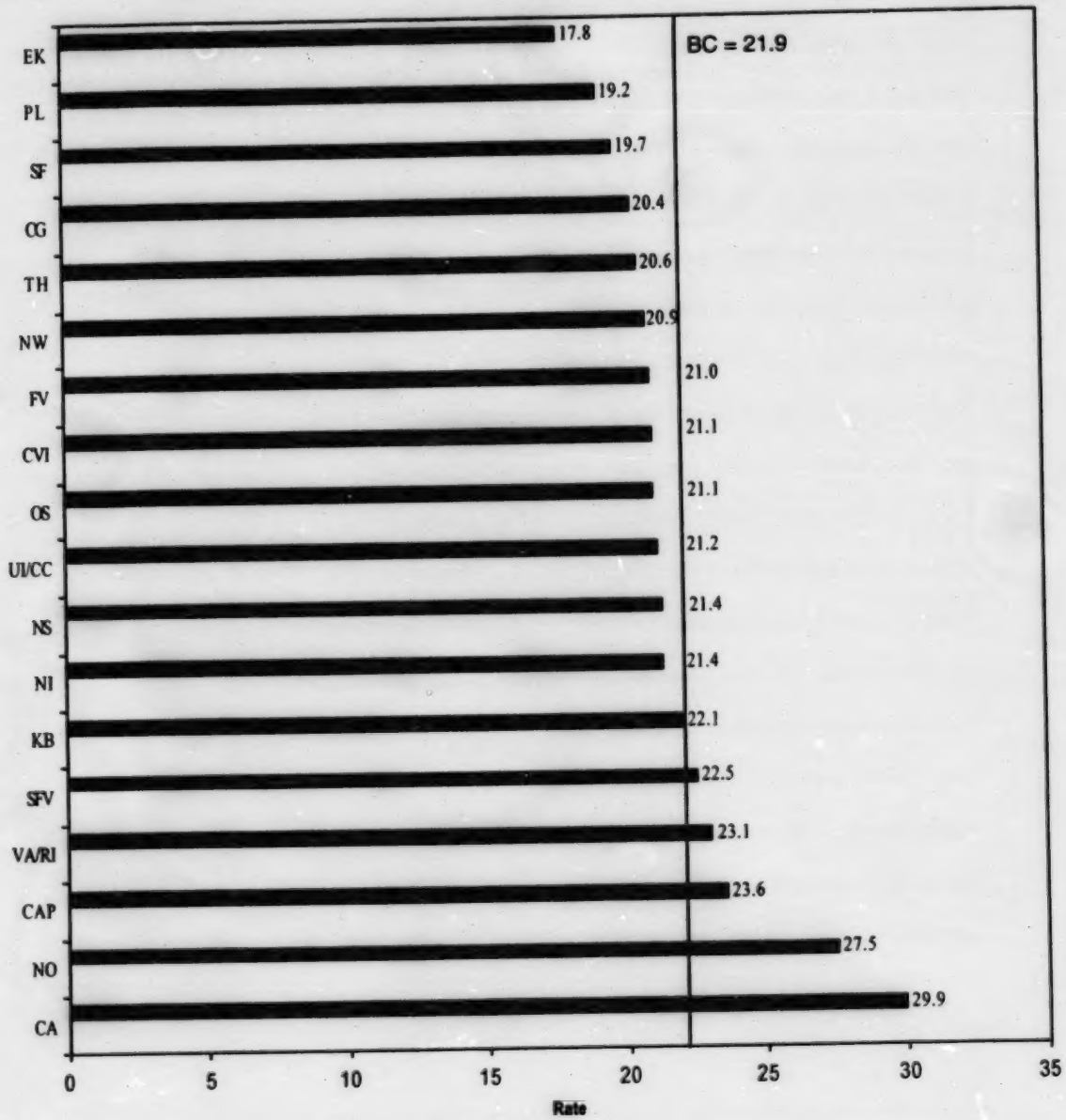
Data provided by: Information Management Group & Information Analysis Branch
Prepared by: Women's Health Bureau, B.C. Ministry of Health

Graph 10: Caesarean Section Births per 100 Live Births by Health Authority, 1999

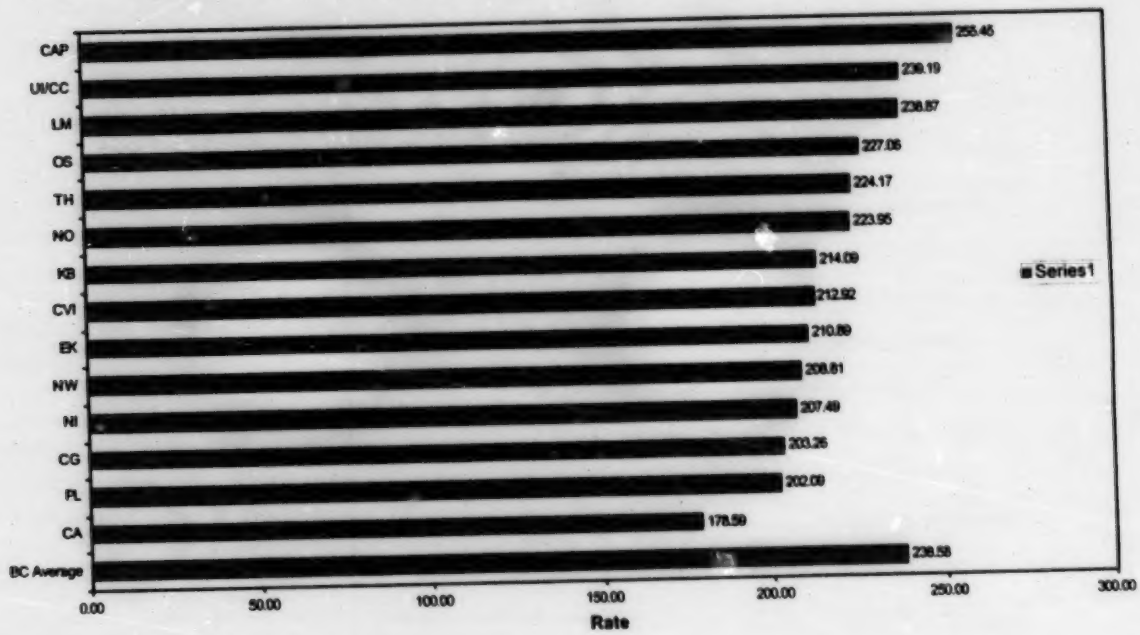


Source: B.C. Vital Statistics Agency, B.C. Ministry of Health
Population information provided by : B.C. STATS & B.C. Ministry of Finance & Corporate Relations
Data provided by: Health Data Warehouse, B.C. Ministry of Health
Prepared by: Women's Health Bureau, B.C. Ministry of Health

Cervical Cancer & Pap Smear Tests

Cervical cancer is the most commonly diagnosed form of reproductive cancer. This is due to the development and widespread usage of the Pap (smear) test. The Pap test detects changes in the cells of the cervix and can therefore determine the presence of precancerous cells called dysplasia (abnormality). Once the dysplasia is treated, the patient is less likely to develop cervical cancer. Widespread use of the Pap test has decreased the occurrence of cervical cancer, leading to a 75 per cent decline in deaths related to this disease. However, approximately 15 per cent of B.C.'s women have never had a Pap test. Many of the unscreened women are immigrant women, Aboriginal women, or women with a low income. Cervical cancer is of a particular concern for young women, as it is the most common type of cancer in women who are under 60 years old.

Graph 11: Average Rates of Pap Smear Tests with the Cervical Cancer Screening Program per 1,000 Women, Age 15 and Over by Health Authority, Between July 1997 and December 1999



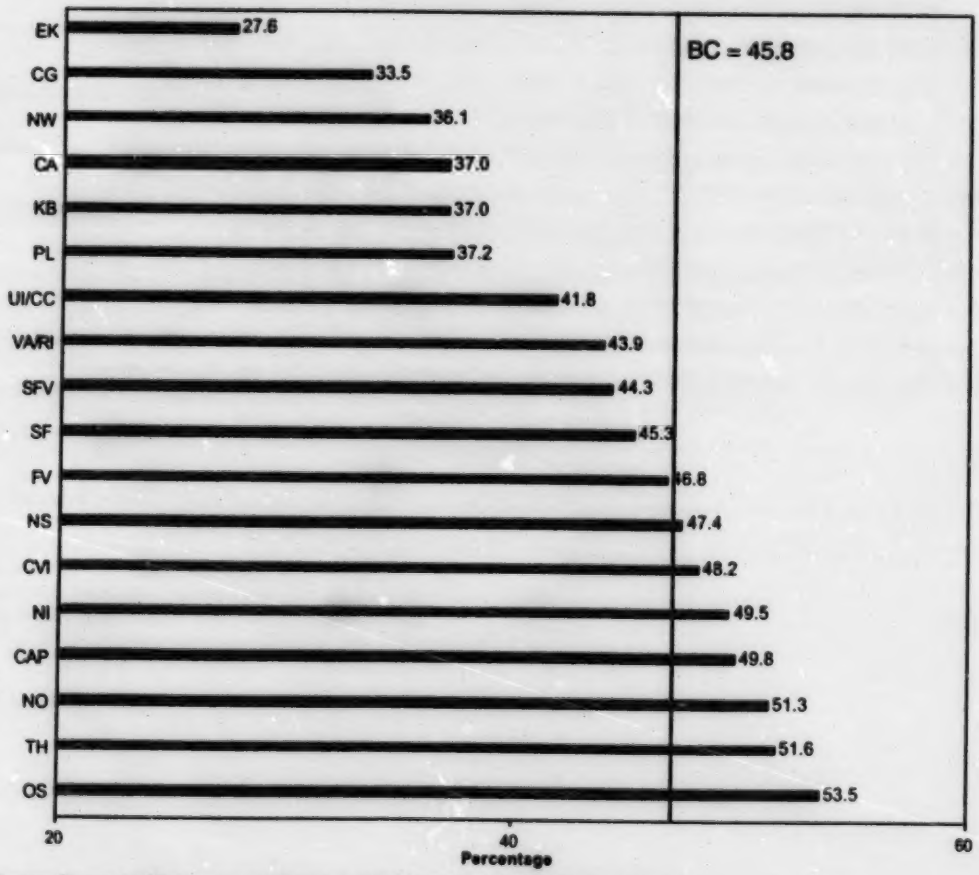
* LM = Lower Mainland (Fraser Valley, South Fraser, Simon Fraser, Vancouver, Burnaby, North Shore, & Richmond)
Source: B.C. Cancer Agency
Data provided by: B.C. Ministry of Finance and Corporate Relations

Screening Mammography

Another accessibility and screening initiative involves the screening mammography program of B.C. (SMPBC). SMPBC mainly targets women between the ages of 50 and 69 years. Screening is not recommended for women below 50 years of age, as their breast tissue is still quite dense and the screening is not as accurate. Women below 50 with a strong incidence of breast cancer in their family lineage are encouraged to speak to their physician about when to begin screening. The goal of reaching 70 per cent of all women in the 50 to 69 age group remains a challenge. Nevertheless, the majority of women screened for breast cancer belong to the target age group.

Equitable access to appropriate services is essential for effective health care in B.C. Since women have more contact with the health care system, it is important that services be appropriate and available to meet their specific needs. It is recommended that health authorities and planners work towards ensuring the provision of necessary services for women in their communities. They should also identify ineffective and inappropriate services and reallocate health care dollars to more effective services such as disease prevention and health promotion activities.

Graph 12: Participation Rate Percentage, Age 50 - 79, for the Screening Mammography Program of B.C. by Health Authority, 1998 to 1999, 24-month period



Source: Screening Mammography Program of British Columbia, B.C. Cancer Agency
Population information provided by: B.C. STATS & B.C. Ministry of Finance & Corporate Relations
Data provided by: Health Data Warehouse, BC Ministry of Health. Prepared by: Women's Health Bureau, B.C. Ministry of Health

GOAL FIVE: IMPROVED HEALTH FOR ABORIGINAL PEOPLES

The social and economic environment in which individuals live shapes their mental and physical health. There is strong evidence that higher income and social status are linked to better health and that lower income, and therefore lower status, are linked to poorer health. Income and social status are amongst the most crucial and important determinants of health.

Compared to the rest of the population, the health status of Aboriginal people in British Columbia is poor. Aboriginal peoples include status Indians who have been legally identified as Indian by the federal government, non-status Indians who are not recognized by the federal government but identify themselves as Indian, and Native/First Nations people which include those listed above as well as Inuit people and Metis people (part Indian and part Caucasian).

Aboriginal people: face the worst socio-economic conditions in Canada; have significantly lower educational levels; experience violence and sexual abuse at higher rates; and, have higher rates of drug, alcohol and solvent misuse.

Children and young people make up approximately 30 per cent of the status Indian population, as compared to 19 per cent for all of British Columbia. While most communities pay increasing attention to an ageing population, the needs of children, youth and young families continue to remain an important focus for Aboriginal health and social services.

Less than half of Aboriginal people live on reserves. Approximately half of the Aboriginal population lives in the southeast side of the province, the lower mainland and Vancouver Island.*

Given the poor health status of the status Indian population as measured by the health indicators, action must be taken to improve the health and well being in Aboriginal communities on and off reserve. Aboriginal people must have meaningful involvement in decision making and planning, as well as improved access to services.

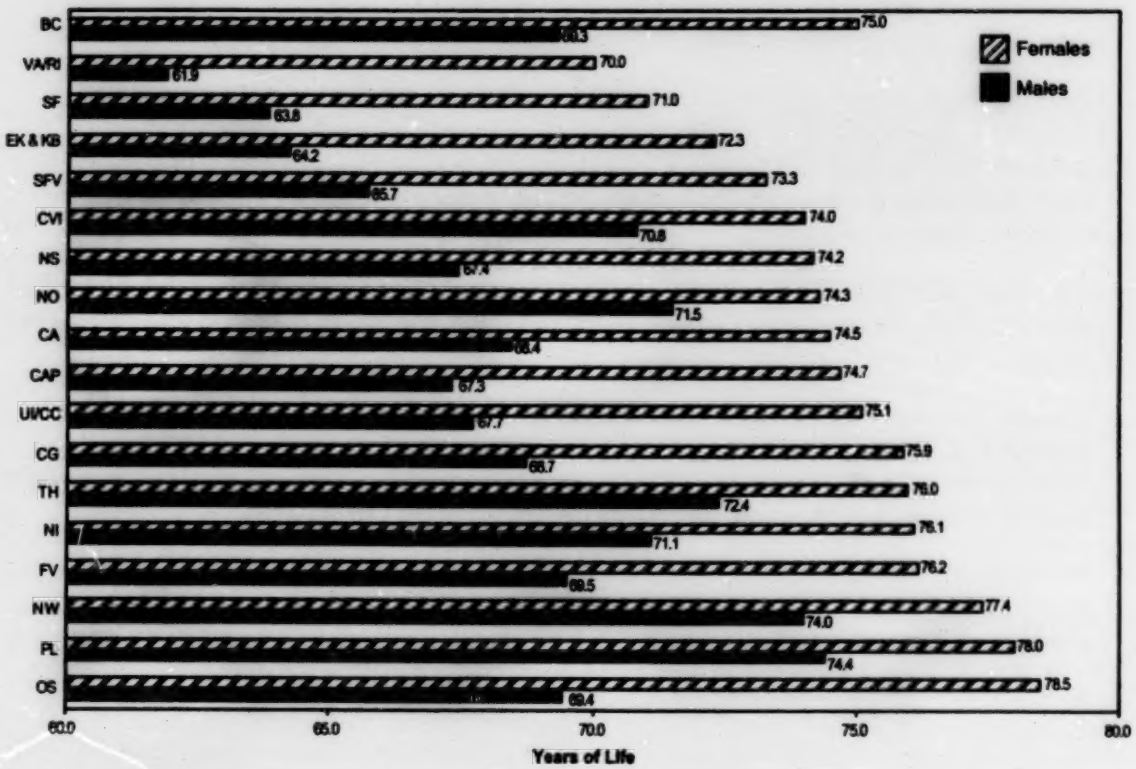
*Refer to appendix B for a health authority breakdown of the female Aboriginal population of B.C.

*Note: Status Indians are one part of a broad group of Native/First Nations peoples in British Columbia. There is interest in the health of all Native/First Nations peoples but because in most cases only data for Status Indians is available, they are the group discussed in this section. Data for Native/First Nation peoples is difficult to collect and further analysis must be conducted in order to truly assess the health status of these people.

Status Indian Life Expectancy

The health status of the Aboriginal people is significantly lower than that of non-Aboriginal people. The average life expectancy for status Indian men in B.C. over the 1995-1999 period was 69.3 years and, for status Indian women, this figure was reported as 75.0 years. As with the rest of the population, status Indian women live longer than their male counterparts by approximately five years. British Columbia as a whole reported life expectancy for men during the 1996-2000 period to be 76.8 years and for women reported life expectancy to be 82.2 years. Overall, the life expectancy rate for status Indian women is approximately seven years less than the provincial life expectancy for all women. The life expectancy rates for status Indians resembles the rates seen in the Canadian population several decades ago.

Graph 13: Status Indian Life Expectancy in British Columbia, by Gender and Health Authority, 1995 - 1999

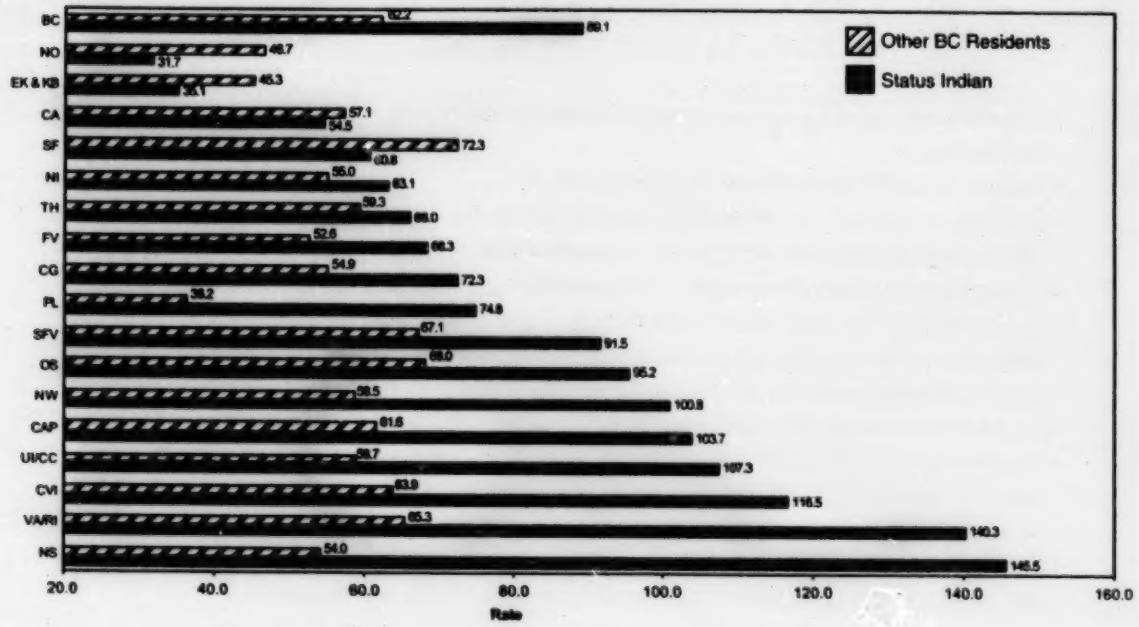


Source: B.C. Vital Statistics Agency, B.C. Ministry of Health
Prepared by: Women's Health Bureau, B.C. Ministry of Health
*Note: For protection of privacy, the EK & KB health authorities have been combined for all status Indian health indicators.

Status Indian Premature Births

The status Indian premature birth rate in B.C. for 1999 was 89.1 per 1000 women compared to the provincial rate of 62.2 per 1000 women. Although the rate for premature births has decreased amongst the status Indian population, there is still concern over the frequency of premature births. Teenage mothers account for a high proportion of premature births as their babies often have lower birth weight than normal. Information and education on how to have a healthy pregnancy is required to help reduce high premature birth rates.

Graph 14: Status Indian and Other B.C. Women Premature Birth Rates per 1,000 Women by Health Authority, 1999

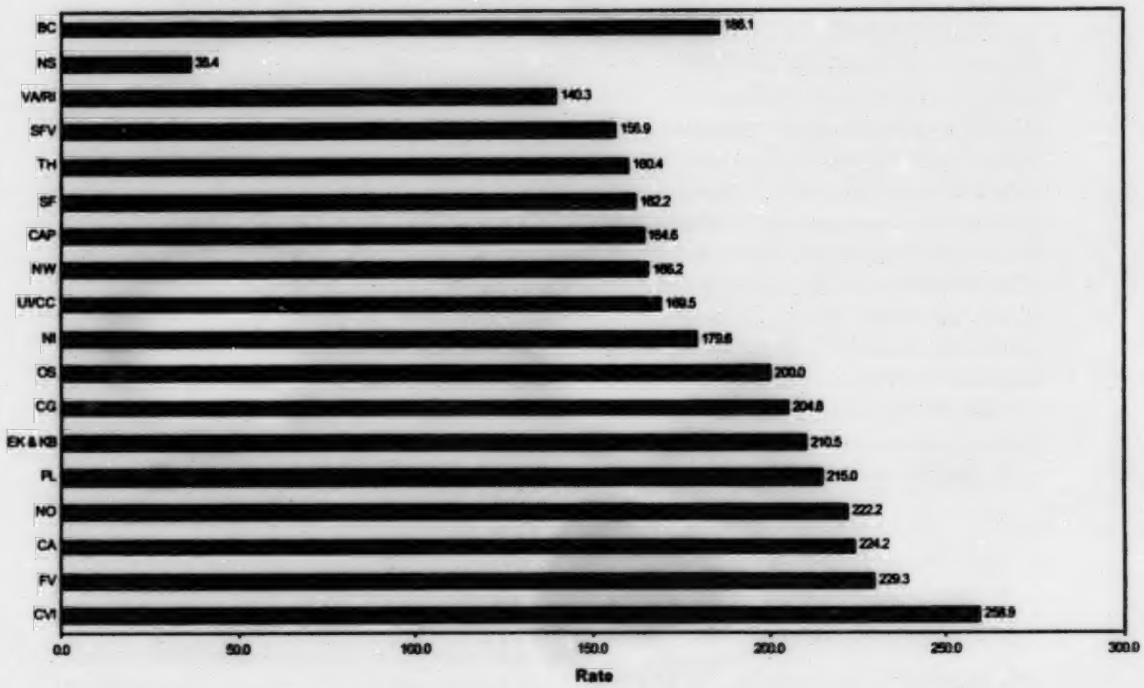


Source: B.C. Vital Statistics Agency, B.C. Ministry of Health
Prepared by: Women's Health Bureau, B.C. Ministry of Health

Status Indian Teenage Mothers

The status Indian teenage mother rate in B.C. for 1999 was reported as 186.1 per 1000 women. Teenage mother rates have declined in the status Indian population but are still significant in comparison to the rest of B.C. In conjunction with the high teenage pregnancy rate, babies of status Indian mothers also account for a large proportion of the low birth weight babies and a significant number of infant deaths caused by Sudden Infant Death Syndrome. It is the responsibility of the health authorities to ensure that young members of the Aboriginal populations receive information on safe sex practices and prevention of unintended pregnancy. Early teenage childbearing is of significant concern as it contributes to poverty and a high dependence on social assistance.

Graph 15: Status Indian Teenage Mother Rate, Below Age 20, per 1,000 Women by Health Authority, 1999

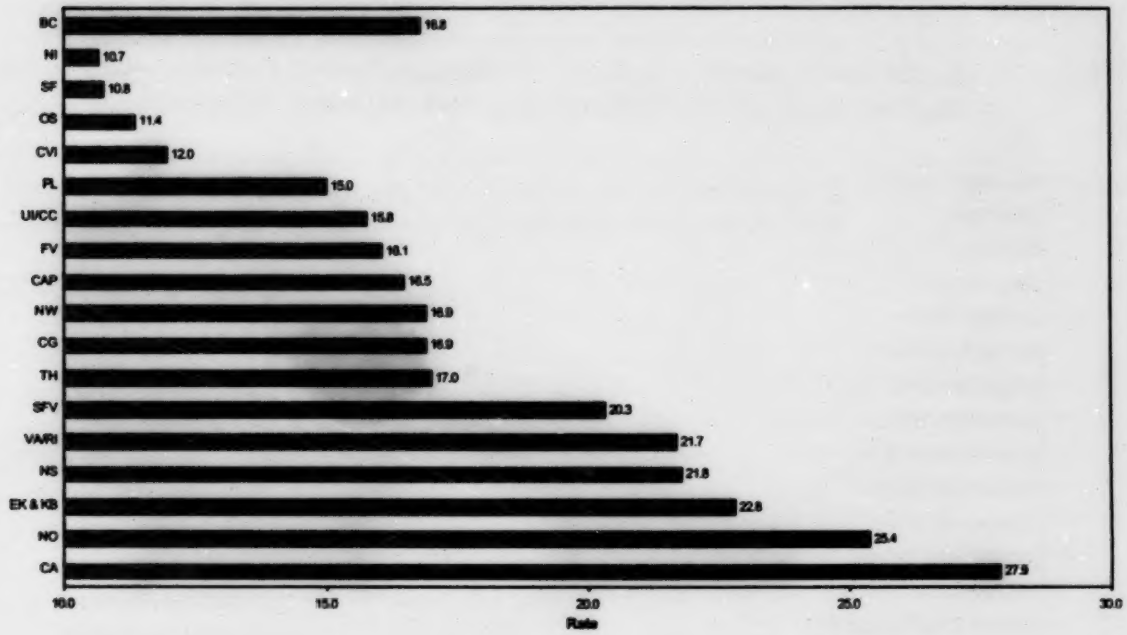


Source B.C. Vital Statistics Agency, B.C. Ministry of Health
Prepared by: Women's Health Bureau, B.C. Ministry of Health

Status Indian Caesarean Sections

The caesarean section rates for status Indian women vary significantly across the province. The provincial rate for 1999 for status Indian women was reported at 16.8. This number, although close to the recommended rate of 15.0 is set by the World Health Organization, is still rather significant.

Graph 16: Status Indian Caesarean Section Births per 100 Live Births by Health Authority, 1999

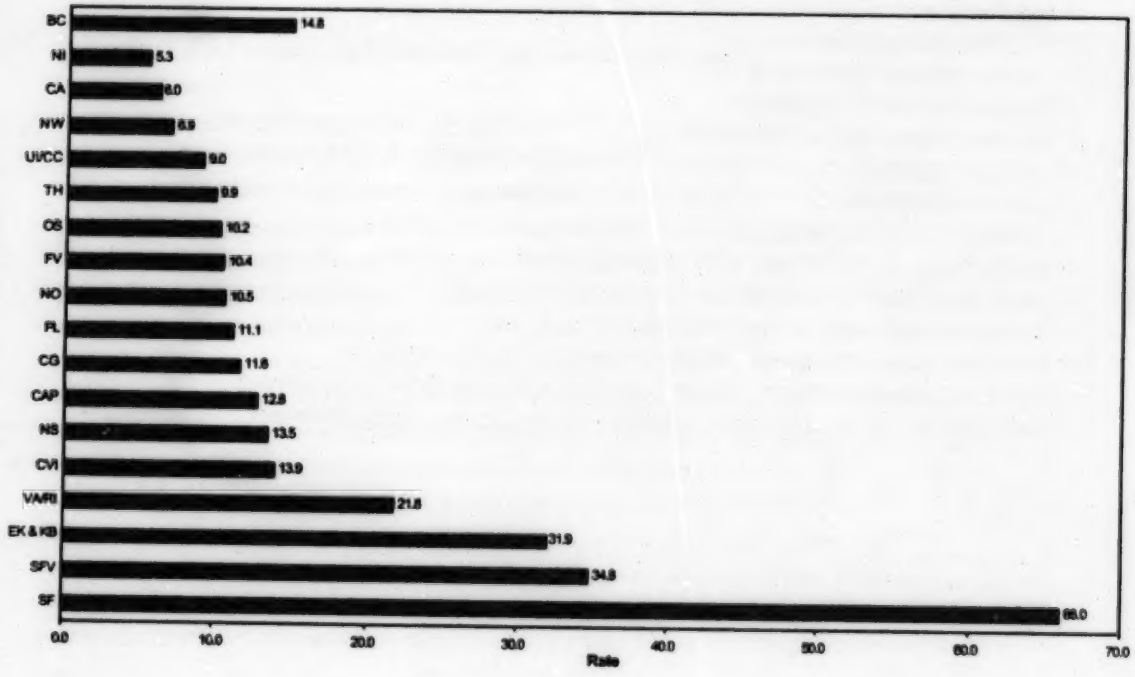


Source: B.C. Vital Statistics Agency, B.C. Ministry of Health
Prepared by: Women's Health Bureau, B.C. Ministry of Health

Status Indian Coronary Heart Disease

Cardiovascular disease is a particular concern for the status Indian population as it is for the entire population of British Columbia. It is the number one killer of both Status Indian women and non-Aboriginal women in B.C. Women need to be concerned about their lifestyle behaviours and the risks that they impose upon themselves in order to prevent the development of the disease. Smoking rates amongst Aboriginal women are considerably high and alleviate the development of coronary heart disease and other heart related disorders. Educational sessions and preventative health measures need to be introduced in order to reduce the mortality caused by this debilitating disease.

Graph 17: Status Indian Age Standardized Female Mortality from Coronary Heart Disease Rates per 10,000 Women by Health Authority, 1991-1999

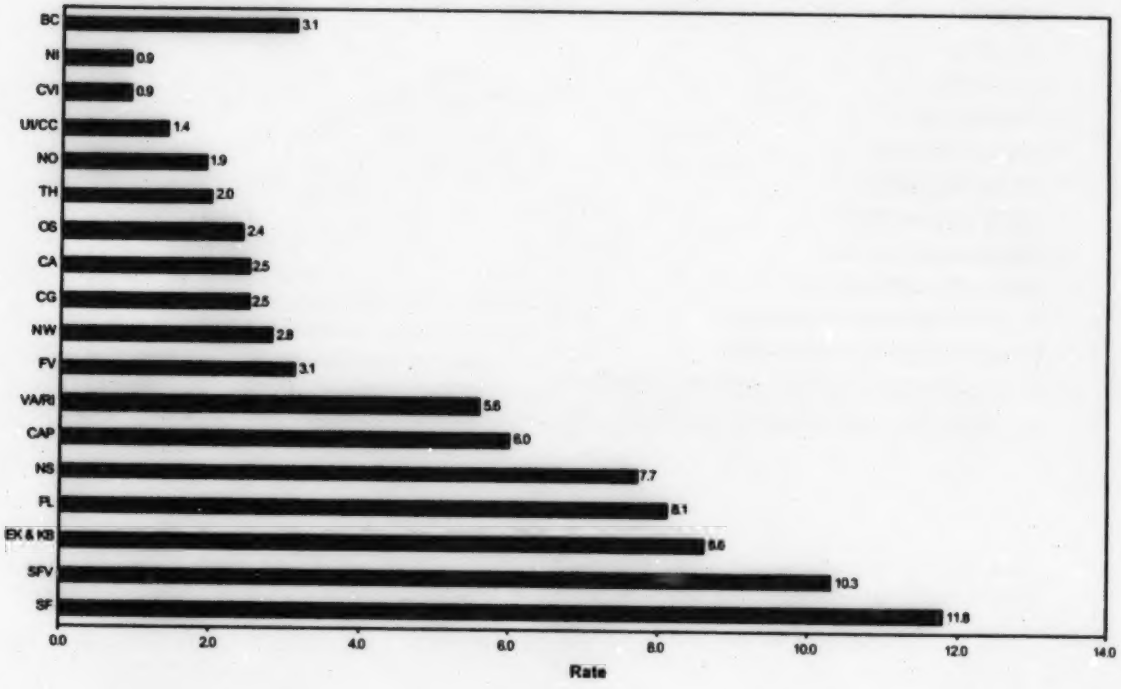


Source: B.C. Vital Statistics Agency, B.C. Ministry of Health
Prepared by: Women's Health Bureau, B.C. Ministry of Health

Status Indian Lung Cancer

Cancer is the second greatest cause of mortality for the status Indian population. Lung cancer is of a particular concern and is the most prevalent form of cancer, mainly caused by the smoking of cigarettes. Smoking and chewing tobacco have been an integral part of the "Indian" way of life for many years. The traditional teachings about tobacco have not been lost. Thousands of Native people use this sacred plant in rituals and ceremonies. Native children are being taught to know tobacco as a sacred plant and medicine. Nevertheless, tobacco misuse is of a significant concern for the Native people in B.C. Nearly 55,000 Native people in B.C. misuse tobacco. Smoking is a highly social practice among the Native population. Family and friends who smoke are the strongest influencing factor on new smokers. Currently, Native females have a 44 per cent tobacco use rate and females in the general population of B.C. have a 21 per cent usage rate. Therefore, lung cancer mortality is of a considerable concern for the Native population of B.C.

Graph 18: Status Indian Age Standardized Female Mortality from Lung Cancer, Rates per 10,000 Women by Health Authority, 1991-1999

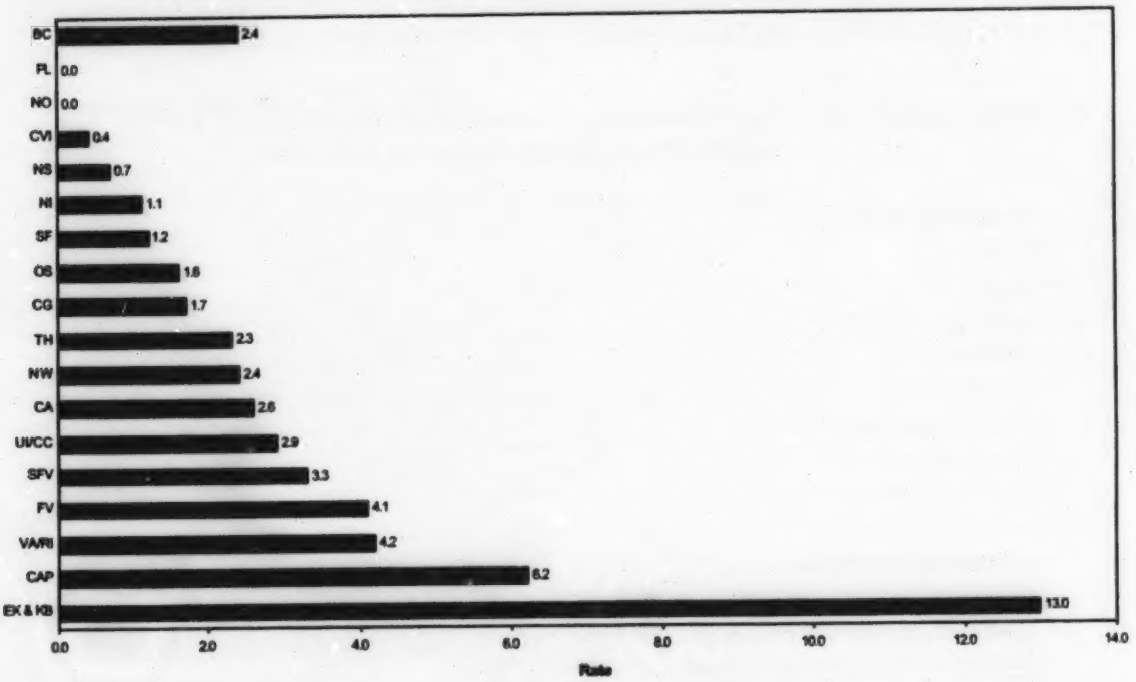


Source: B.C. Vital Statistics Agency, B.C. Ministry of Health
Prepared by: Women's Health Bureau, B.C. Ministry of Health

Status Indian Breast Cancer

Breast cancer is also an issue of concern for status Indian women. Incidence levels may be attributed to a reduced participation rate in the screening mammography program of B.C. (SMPBC) by status Indian women. Women aged 50 to 69 need to be more informed about the risks of breast cancer and about the benefits of participation in the SMPBC. status Indian women and other Aboriginal women need to take part in regular breast screening in order to help lower the mortality caused by breast cancer.

Graph 19: Status Indian Age Standardized Female Mortality from Breast Cancer, Rates per 10,000 Women by Health Authority, 1991-1999

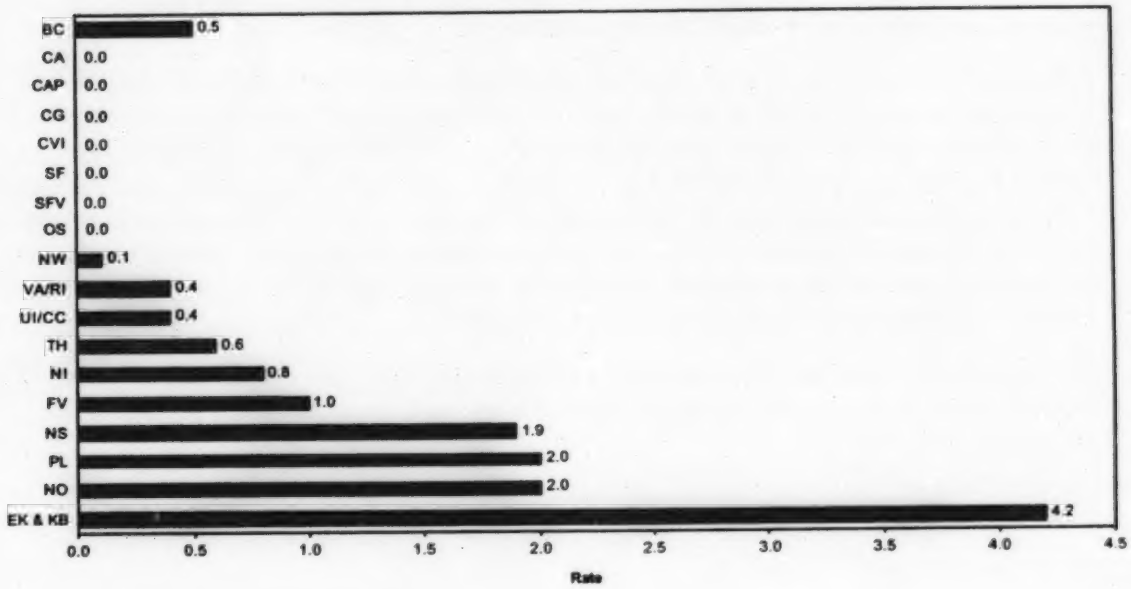


Source: B.C. Vital Statistics Agency, B.C. Ministry of Health
Prepared by: Women's Health Bureau, B.C. Ministry of Health

Status Indian Cervical Cancer

For status Indian women, reproductive cancer, specifically cervical cancer, is yet another concern. Cervical cancer is the most preventable form of cancer, yet it is often more prevalent among status Indian women than other B.C. women. The reason for this high rate is linked to the fact that status Indian women are less likely to take part in regular Pap testing which is essential for early detection and subsequent prevention of cervical cancer. Methodologies on how to encourage Aboriginal women to take part in regular pap testing and an understanding of their sensitive cultural issues must be sought out in order to help lower the number of deaths caused by cervical cancer.

Graph 20: Status Indian Age Standardized Female Mortality from Cervical Cancer, Rates per 10,000 Women by Health Authority, 1991-1999



Source: B.C. Vital Statistics Agency, B.C. Ministry of Health
Prepared by: Women's Health Bureau, B.C. Ministry of Health

GOAL SIX: REDUCTION OF PREVENTABLE ILLNESS, INJURIES, DISABILITIES AND PREMATURE DEATHS

Violence and Health

When women are asked about their most pressing health concerns, violence often tops the list. Nevertheless, violence has traditionally been viewed as a justice issue rather than a health issue. This perception is erroneous, since the cost of violence to the Canadian health care system is estimated at $4 billion per year. In B.C. alone, the cost is measured at $400 million per year. The indirect costs to the health care system, such as increased physician visits for complications resulting from stress and the personal costs to the women themselves have yet to be calculated.

Although both men and women experience violence, women are far more likely to experience certain types of violence, such as sexual assault and assault by an intimate male partner (spousal assault). Women in lesbian relationships also can experience violence by their intimate partners. Elderly women, especially single or widowed women encounter elder abuse as well. Violence against women occurs in many different forms, including harassment, sexual abuse, financial and psychological abuse, neglect, exploitation, and physical violence. All forms of violence significantly affect all aspects of health — mental, spiritual, physical, and emotional.

Not surprisingly, women who experience violence use a greater proportion of health care services than do non-abused women. Several long-term physical health problems are associated with violence:

- arthritis;
- chronic pain;
- hearing loss;
- sexually-transmitted diseases;
- chronic bowel problems;
- pelvic inflammatory disease; and,
- neurological damage.

In B.C., 59 per cent of women have experienced at least one incident of physical or sexual violence since the age of 16. B.C. ranks first when compared to other provinces in Canada for recorded incidents of violence against women; one in two women are victims of sexual assault, one in three of wife assault, and one in five of other types of physical assault (Ministry of Women's Equality, 1998).

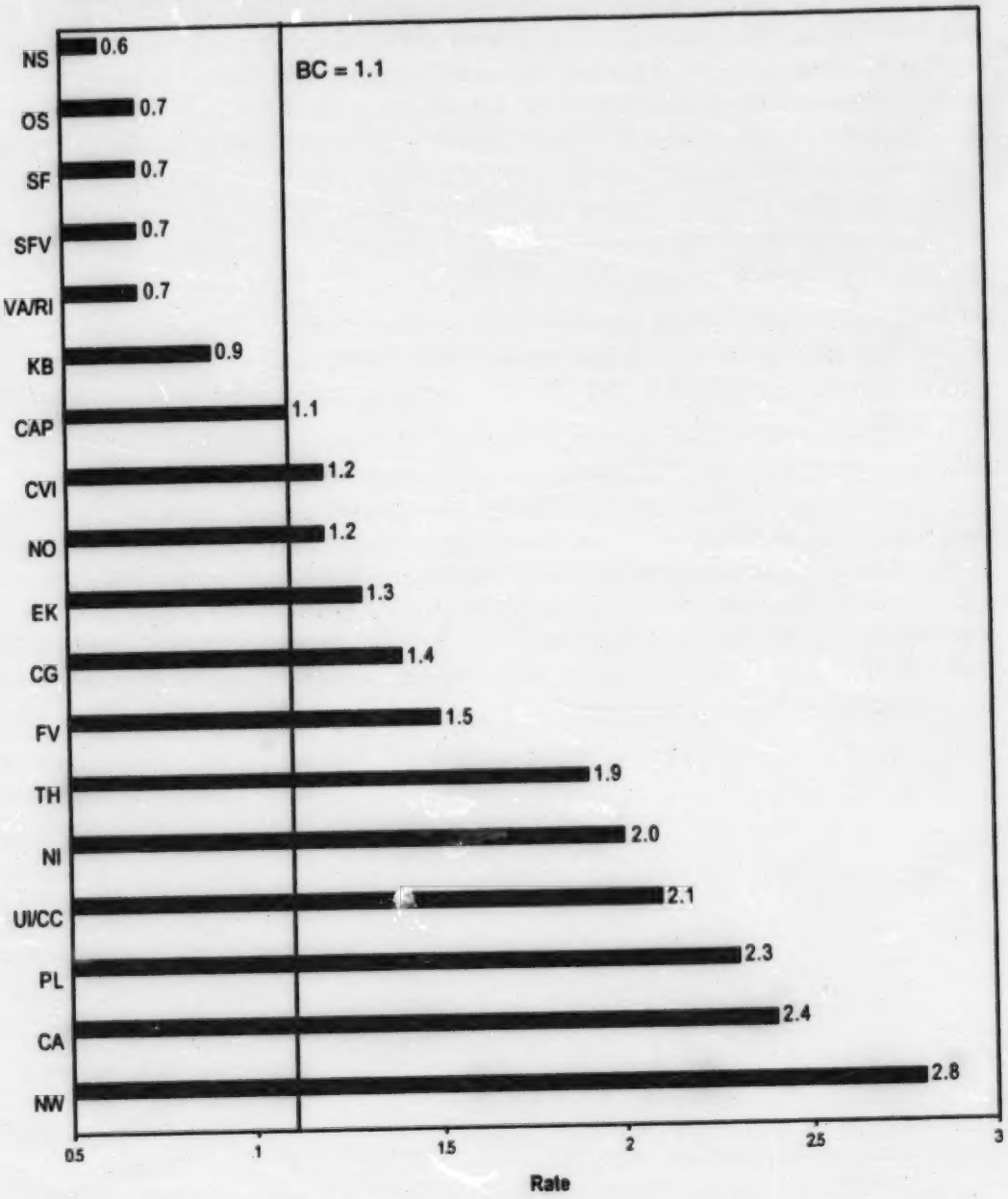
Sexual Assault

According to a violence against women survey in 1995, 39 per cent of Canadian women have experienced at least one incident of sexual assault since the age of 16. In 1998, a total of almost 5,000 sexual assaults and other sexual offences were reported to police in B.C. Eighty-seven per cent of the sex crimes reported were classified as Level 1 sexual assault, defined as any form of forced sexual activity without bodily harm. Two per cent were classified as Level 2 sexual assaults, which occur when someone uses or threatens to use bodily harm or a weapon in the course of a sexual assault. Level 3 sexual assaults, which occur when a person wounds, maims, disfigured, beats or endangers the life of a person during a sexual assault, accounted for 1 per cent of the sexual offences. Of those charged with sexual offences in 1998, 98 per cent were male.

Relatively few sexual assaults are ever reported to the police — only an estimated 6 per cent. When viewing the statistics on sexual assault, it is important to recognize that the reported incidences represent only a fraction of the actual numbers of sexual assaults that take place.

Race, cultural background, and language barriers contribute to the lack of reported incidences of abuse to the police and health care system. Immigrant women and marginalized women often find it more difficult to report violence because of fear of further and more severe acts of violence. They may also fear exclusion from the cultural community and fear the possibility of being deported. Women of marginalized populations may also find it difficult to access services and providers who understand their culture and language. Therefore, these women often refrain from getting the health care services that they greatly require.

Graph 21: Total Sex Offences Reported to Police, Rates per 1,000 Total Population by Health Authority, 1999

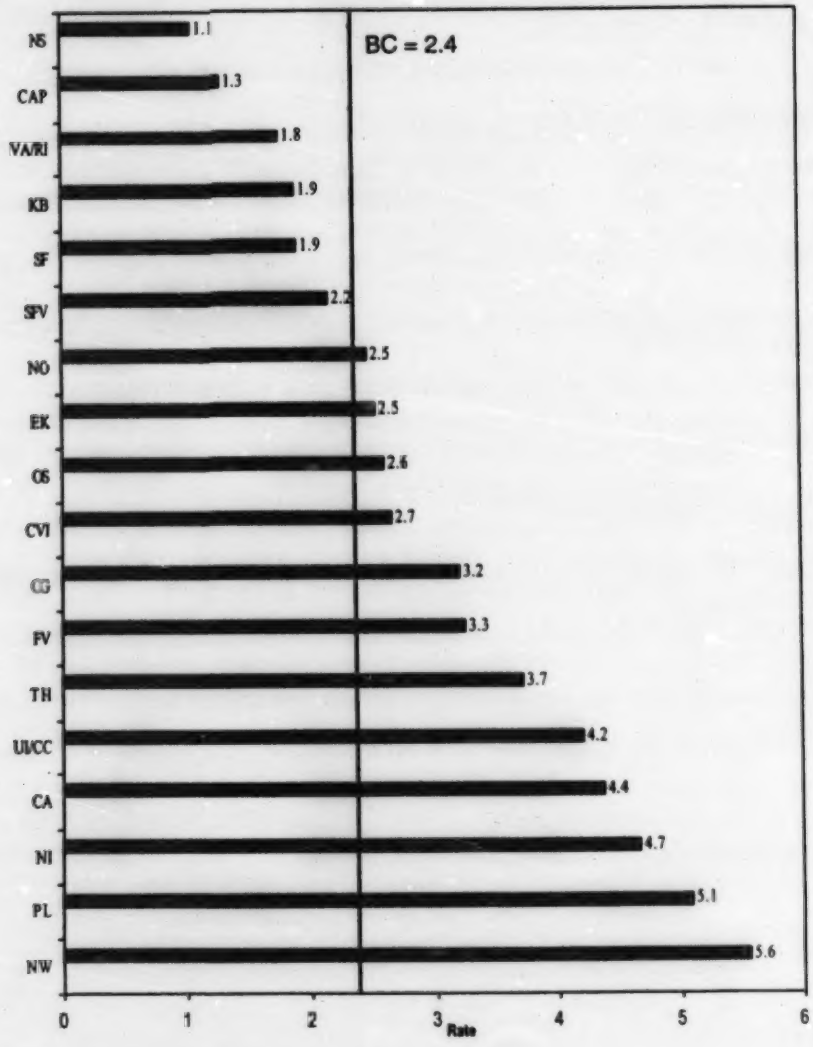


Source: Sexual Offence Statistics: Uniform Crime Reporting Survey, Police Services Division, B.C. Ministry of Attorney General
Population information provided by: B.C. STATS & B.C. Ministry of Finance & Corporate Relations
Data provided by: Health Data Warehouse, B.C. Ministry of Health
Prepared by: Women's Health Bureau, B.C. Ministry of Health
Note: Total sex offences includes sexual assaults, Level 1, Level 2 (Weapon/Bodily Harm), Level 3 (Aggravated) and other sexual offences such as sexual interference, invitation to sexual touch, sexual exploitation, and incest.

Assault by an Intimate Male Partner

In Canada, at least one in eight women is physically and/or sexually assaulted by her husband or male partner. Women are 13 times more likely to be assaulted in their own home by their partner than by a stranger on the streets. As with sexual assault, many cases of intimate-partner assault go unreported because of factors such as fear of reprisal by the assailant. On average, a woman is assaulted eight times before a report is filed with the police. Of the 9,500 reported incidents of spousal assault in B.C. in 1998, 81 per cent involved a male offender, 9 per cent involved a female offender, and 10 per cent involved both spouses assaulting each other. Almost 50 per cent of all spousal assault incidents were alcohol-related.

Graph 22: Spousal Assaults Reported to Police, Rates per 1,000 Total Population by Health Authority, Annual Average, 1997-1999



Source: Police Services Division, B.C. Ministry of Attorney General
Population information provided by: B.C. STATS & B.C. Ministry of Finance & Corporate Relations
Data provided by: Health Data Warehouse, BC Ministry of Health
Prepared by: Women's Health Bureau, B.C. Ministry of Health

In summary, eradicating violence is crucial to the health of women and their families. The physical, emotional, social, and economic costs of sexual and physical violence against women have been recognized as a primary health concern. Violence in all forms prevents women from seeking health care. Sometimes emotionally abusive partners may prevent women from going to medical appointments and women themselves may be fearful of disclosing violence to a health care worker. Nevertheless, women who have experienced violence have more contact with the health care system, both for mental and physical care as a direct result of violence and/or for related indirect health care such as hearing loss and gastrointestinal conditions. The health care system is often the first place a woman comes in contact with a professional and has the opportunity to disclose her situation or seek support. For women who have been sexually assaulted, emergency health care may be their first point of contact for assistance. Given the impact of violence on women's health and the health care system, it is recommended that health planners develop an integrated response with the network of services that already exist to support and protect women who experience violence.

Illness and Premature Deaths of Women

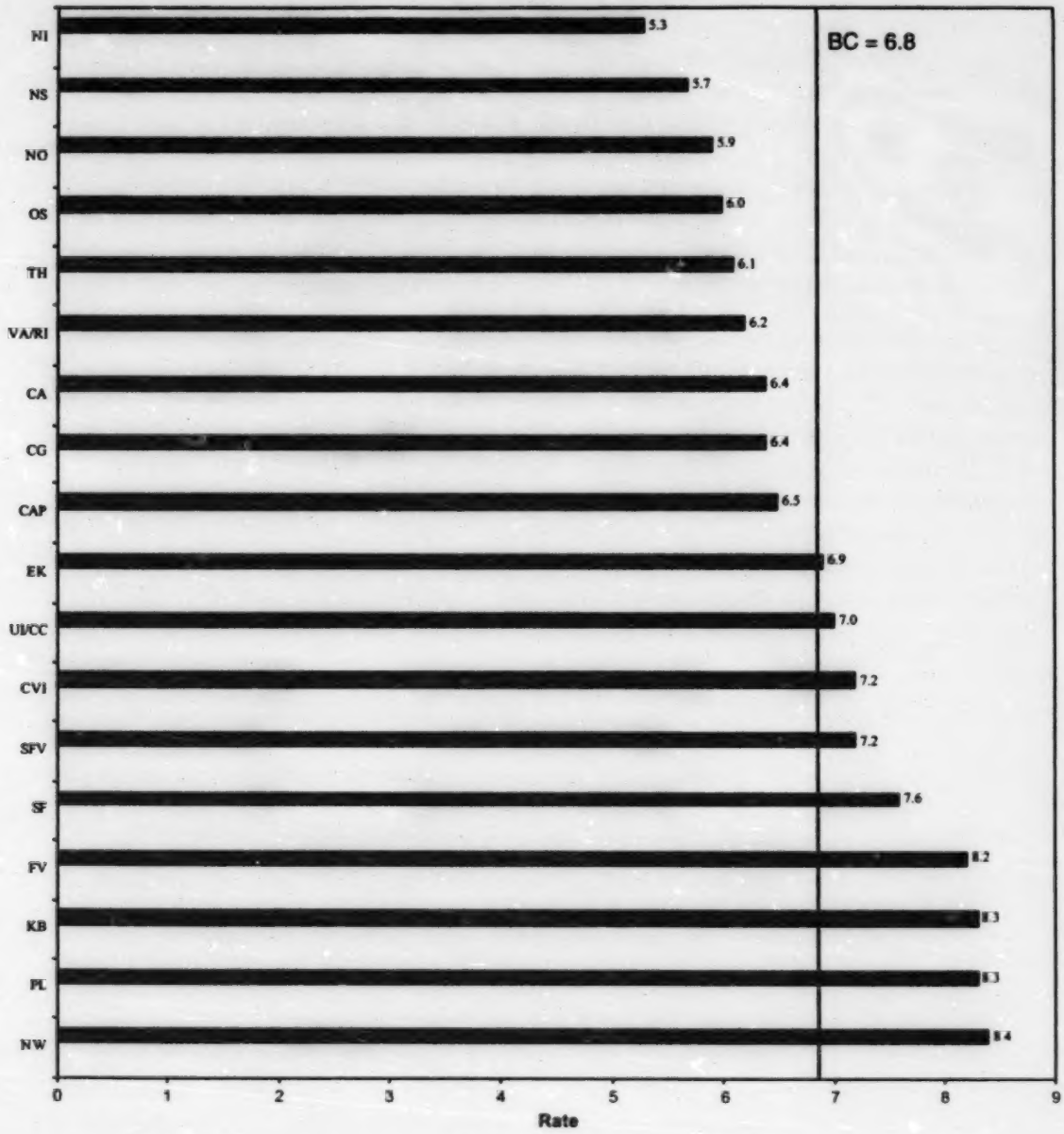
Women in B.C. live longer than men and are more likely to experience age-related disabilities, injuries, and illnesses. Women's longer life expectancy is associated with longer periods of living with disease and coping with some degree of dysfunction.

Coronary Heart Disease

Cardiovascular disease (CVD) is the leading cause of death among women in B.C. CVD is a broad category of conditions that affect the heart and bloodstream, the most common type being coronary or ischaemic heart disease, where the heart muscle function is impaired by a reduced blood supply. Although death rates from coronary heart disease have declined in recent years, it still ranks as the number one cause of death for women. Several factors place women at risk for this disease such as smoking, high blood pressure, physical inactivity, obesity, and diabetes. These risk factors are more prevalent as women age. The greater the number of risk factors a woman has, the more she should focus on prevention. Women need to be aware of the risks of heart disease and begin at an early age to take charge of their own heart health.

Since CVD has traditionally been considered a "man's disease", the health care system has only recently begun to address the unique nature of women's heart health. It is becoming more widely accepted that women experience heart disease differently than men — including initial symptoms, time lapsed before they contact a health care professional, and reaction to treatment. Much more needs to be done to address this number one killer of women in B.C.

Graph 23: Age Standardized Female Mortality from Coronary Heart Disease, Rates per 10,000 Women by Health Authority, 1999



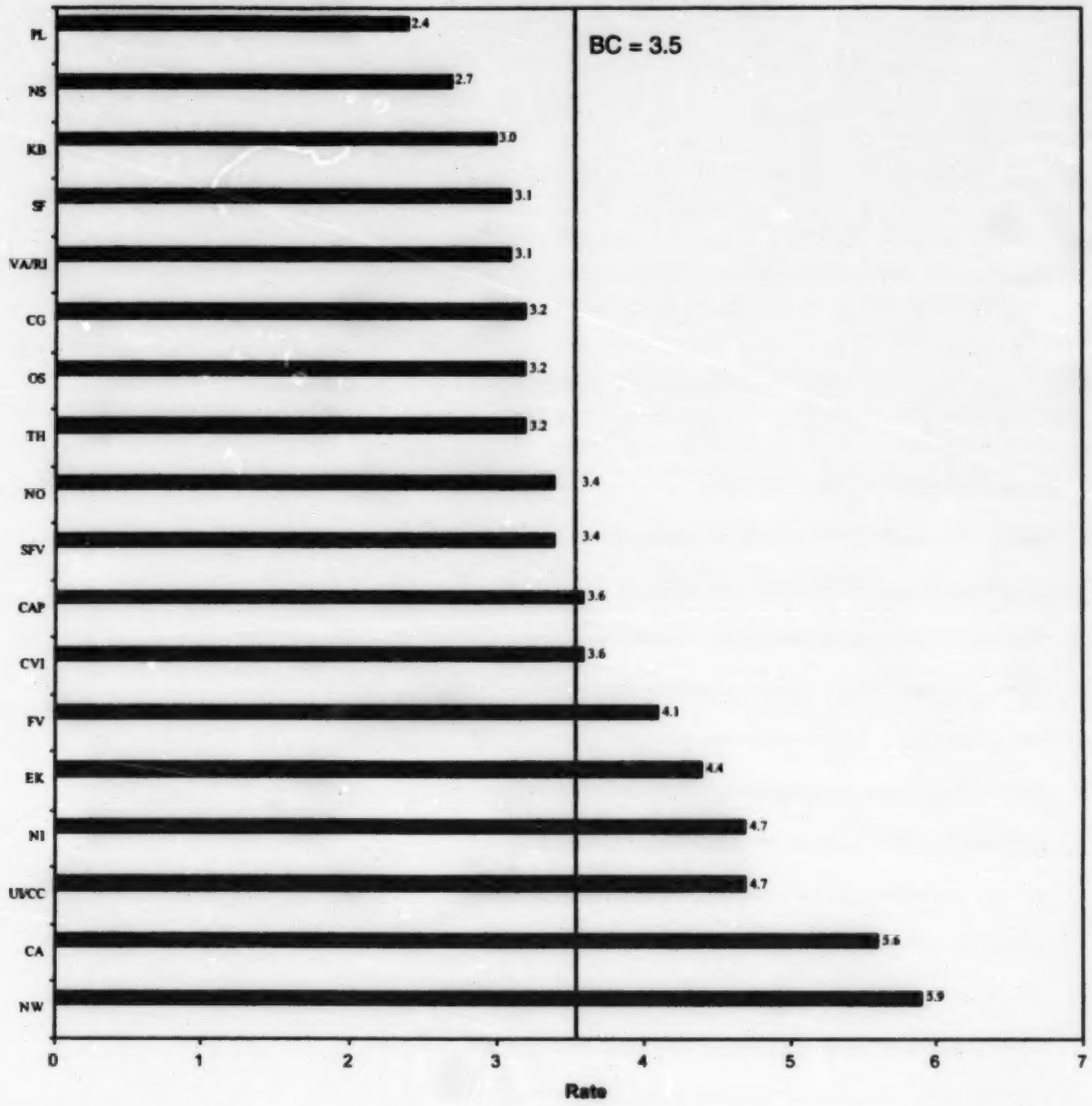
Source: B.C. Vital Statistics Agency, B.C. Ministry of Health
Population information provided by: B.C. STATS & B.C. Ministry of Finance & Corporate Relations
Data provided by: Health Data Warehouse, B.C. Ministry of Health
Prepared by: Women's Health Bureau, B.C. Ministry of Health

Lung Cancer

Cancer is the second leading cause of death among women in B.C. Although there are many forms of cancer, lung cancer is the number one cause of cancer deaths among women. The rate of survival after a diagnosis of lung cancer is very low. Only 15 per cent of the affected population will recover because there is no effective test to diagnose the disease at an early stage and few treatments are available for advanced lung cancer. Once diagnosed with lung cancer, more than 80 per cent of patients die within five years. Lung cancer is a largely preventable disease since the main cause is cigarette smoking. Although the effects of tobacco are well known, more than one in five women smoke in B.C. The Canadian Cancer Society reports that cigarette smoking causes an estimated 90 per cent of lung cancer cases.

The effects of smoking on women are significant, especially since there is evidence that women are two to three times more susceptible to the cancer-causing effects of tobacco smoke than men. Since lung cancer is directly linked to smoking, prevention efforts must focus on eliminating tobacco use among women and men. To address the issue of tobacco use among women, the differences between women and men must be understood and used to guide program planning and delivery. For example, women smoke for different reasons than men, are more susceptible to tobacco addiction, are more physiologically vulnerable to the toxic effects of smoke, and need different support strategies for quitting. Therefore, it is imperative that smoking cessation programs recognize issues of gender in their program content and method of delivery.

Graph 24: Age Standardized Female Mortality from Lung Cancer, Rates per 10,000 Women by Health Authority, 1999

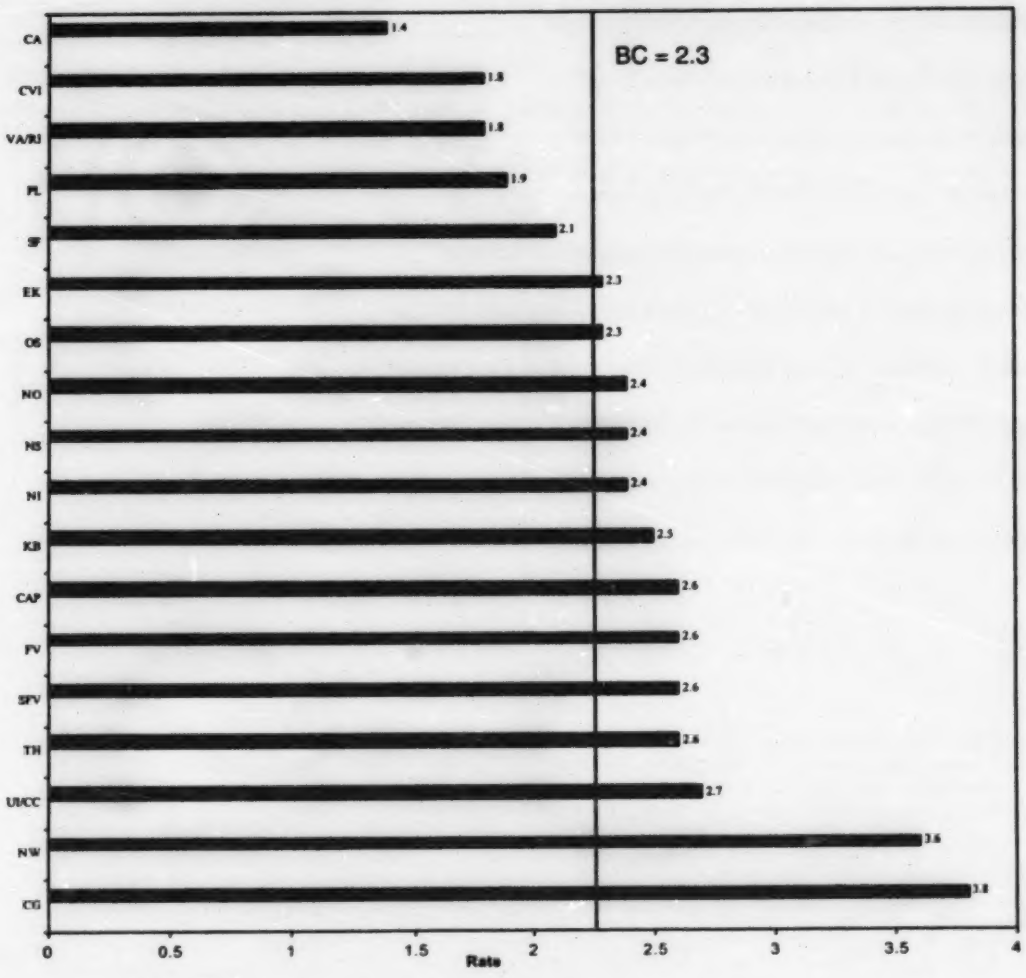


Source: B.C. Vital Statistics Agency, B.C. Ministry of Health
Population information provided by: B.C. STATS & B.C. Ministry of Finance & Corporate Relations
Data provided by: Health Data Warehouse, B.C. Ministry of Health
Prepared by: Women's Health Bureau, B.C. Ministry of Health

Breast Cancer

Although lung cancer is the most common type of cancer death, breast cancer is the most commonly diagnosed cancer among women. This is partly because of early diagnosis through screening mammography. Women aged 50 and over are most at risk for developing breast cancer, and are encouraged to be screened through the screening mammography program of B.C. every two years. Statistics Canada reports that the lifetime probability of developing breast cancer for a woman is 10.6 per cent. The lifetime probability of dying from breast cancer is reported to be 3.9 per cent. Although it is not yet known how to prevent breast cancer, appropriate use of screening mammography increases the likelihood of detection, thus allowing for earlier medical intervention at a stage of the disease where a cure is more likely.

Graph 25: Age Standardized Female Mortality from Breast Cancer, Rates per 10,000 Women by Health Authority, 1999



Source: B.C. Vital Statistics Agency, B.C. Ministry of Health
Population information provided by: B.C. STATS & B.C. Ministry of Finance & Corporate Relations
Date provided by: Health Data Warehouse, B.C. Ministry of Health
Prepared by: Women's Health Bureau, B.C. Ministry of Health

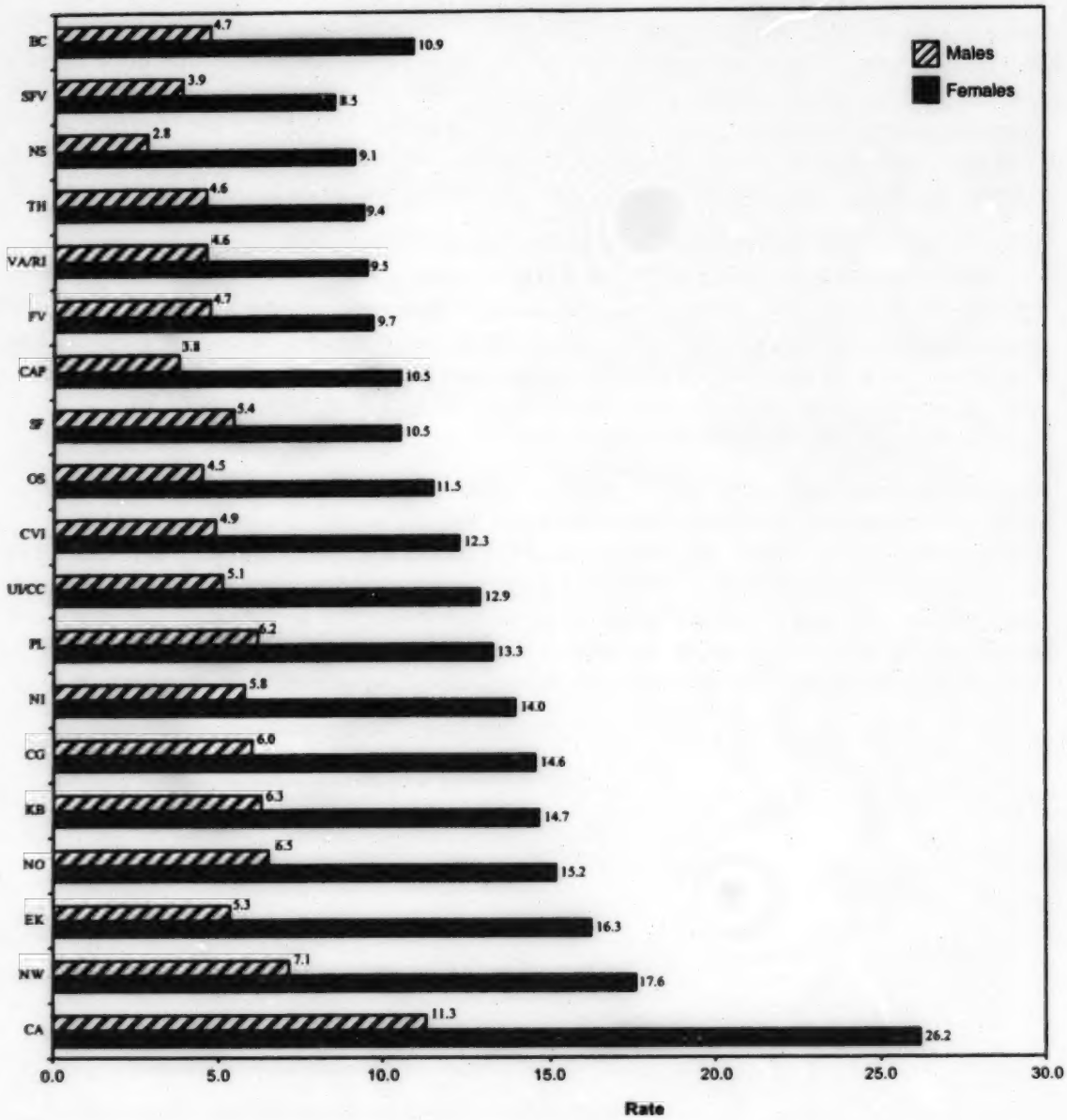
Hip Fractures

Osteoporosis is a disease of brittle bones that break, sometimes with little external force. Osteoporotic fracture can be a very painful disease and can impair one's quality of life. Since osteoporosis is asymptomatic until fracture, bone mineral density testing is used to diagnose osteoporosis in advance of fracture. However, evidence shows that bone density test results are poor predictors of future fracture. Therefore, efforts to reduce osteoporosis must focus both on building and maintaining strong bones throughout the life span as well as on reducing the primary cause of fractures – falls. Since women are tested for bone density 17 times more often then men, they are more likely to be labelled osteoporotic.

Women are more at risk for bone fragility than men are because age is the best predictor of fracture and there are more elderly women then men. Also, after menopause, women experience bone density loss at a much higher rate than men. At age 55, the hospitalization rate for falls begins to increase among women, such that the rate is double the rate for men by age 75. Women are hospitalized two to three times more often than men as a result of fractures. Among women aged 65 and over, falls account for approximately 6,000 hospitalizations per year.

Hip fractures can lead to permanent disability and even death for women, as 15 per cent of victims die shortly after a fracture and 30 per cent die within one year of their fall. Preventative measures can help reduce the high rate of fracture hospitalizations caused by falls. As the female population ages and the life expectancy for women increases, hip fractures will become a more common cause of hospitalization and disability among women in the future years to come. Health planners need to take more initiative in the area of preventative health and education to help the elderly avoid falls and fractures.

Graph 26: Hospitalizations Due to Hip Fractures, Rates per 1,000, Age 65 and Older by Gender and Health Authority, 1999/2000



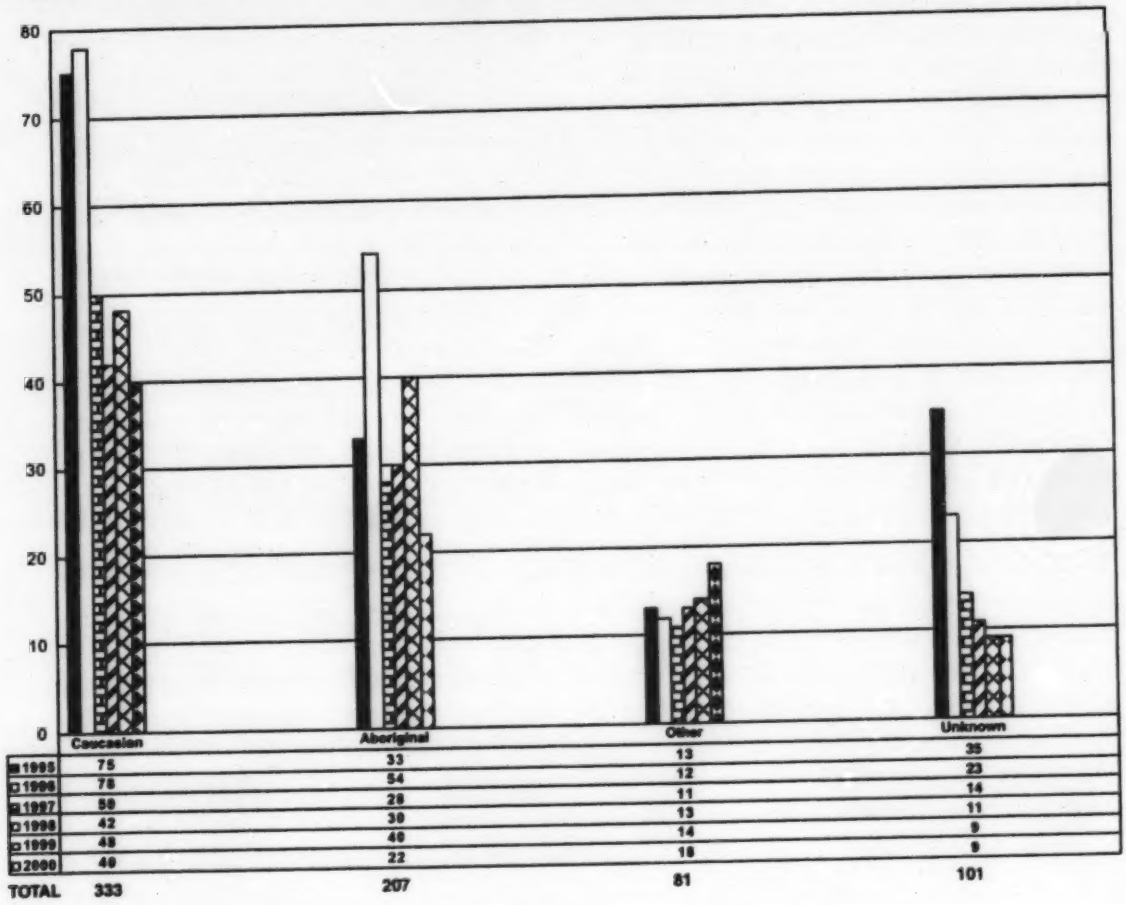
Source: Information & Analysis Branch, B.C. Ministry of Health
Population information provided by: B.C. STATS & B.C. Ministry of Finance & Corporate Relations
Data provided by: Health Data Warehouse, B.C. Ministry of Health
Prepared by: Women's Health Bureau, B.C. Ministry of Health

HIV/AIDS

HIV/AIDS is a continuing and increasing problem for both women and men in the province of B.C. HIV is spread through the exchange of bodily fluids, specifically blood, semen, vaginal secretions, pre-ejaculatory fluid and breast milk. The main routes of transmission are through activities such as unprotected vaginal or anal intercourse, injection drug use, and from mother to child though breastfeeding. There has been a substantial increase in the number of women testing positive for HIV, especially economically disadvantaged women, Aboriginal women, and Caucasian women. As data indicate, HIV infections among women were quite significant and steadily increased until 1996, after which they began to decline until 1999, when the infection rate once again began to rise. This is in part due to the increase of injection drug usage among women and in part to their receiving role in vaginal and anal sexual intercourse as a result of their physical anatomy and fragile tissues. Semen has also been found to contain higher concentrations of the HIV virus than vaginal secretions, thus putting women at an even greater risk for infection. It has been well documented that when the virus is exposed to blood or blood products, the transmission is fiercer. If a woman or her partner has a pre-existing STD, she/he is three to five times more likely to acquire HIV if exposed to the virus.

Women need to be aware of the health risks surrounding HIV/AIDS and should be educated on how to protect themselves from contracting HIV. Women also need information on where to go and what to do if they have been sexually assaulted with respect to HIV infection. Infected women need information about treatment measures, counseling agencies, and anti-viral drugs which dramatically decrease the risk of HIV contraction from mother to child for pregnant women carrying the virus. Preventive strategies need to reach women and must be sensitive to women's particular issues and needs in order to reduce the infection rate and exposure of this deadly disease.

Graph 27: Female Populations Testing Newly Positive for HIV by Year, B.C., 1995 to 2000



	Caucasian	Aboriginal	Other	Unknown
1995	75	33	13	35
1996	78	54	12	23
1997	50	28	11	14
1998	42	30	13	11
1999	48	40	14	9
2000	40	22	18	9
TOTAL	333	207	81	101

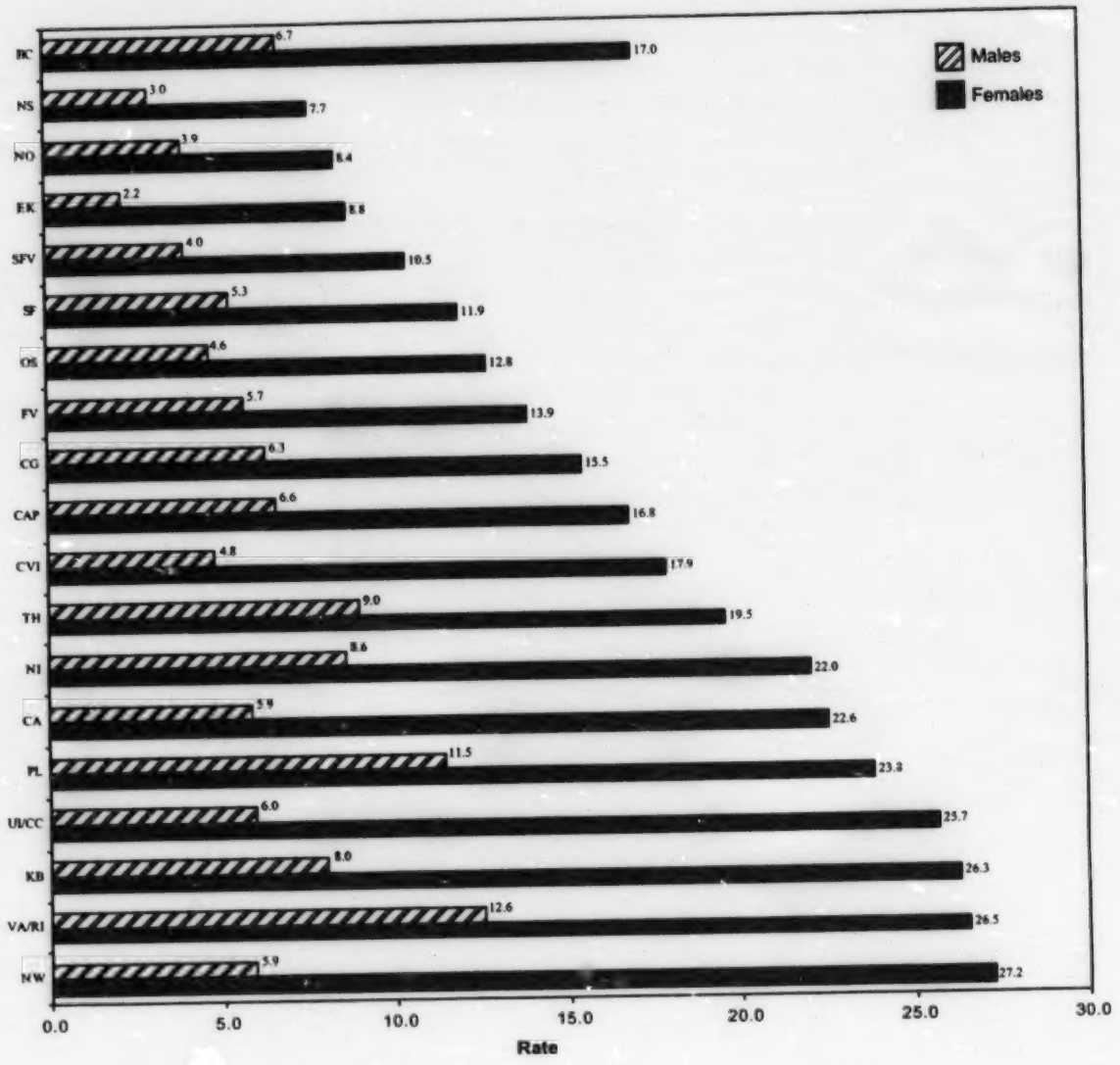
Source: HIV/AIDS Update Year End, B.C. Centre for Disease Control Society (STD/AIDS Control)
Prepared by: Women's Health Bureau, B.C. Ministry of Health
* Note: The "Other" category contains members of other ethnic populations. The "Unknown" cases may contain members of the other designated populations

Chlamydia

Chlamydia is the most common sexually transmitted disease in Canada, and until recently, the most silent and hidden sexually transmitted infection. If left untreated, the bacterial infection can have devastating consequences for women. Chlamydia is often prevalent in sexually active females aged 15 to 24. About one-half of women and 70 per cent of men who are infected with the disease experience symptoms. For women, the symptoms are a change in vaginal discharge, pelvic pain or deep pain during intercourse. Even if there are no symptoms, the bacteria can severely damage the fallopian tubes.

Chlamydia is the most common cause of pelvic inflammatory disease and is responsible for approximately 85 per cent of tubal infertility cases and nearly one-half of ectopic pregnancies. Women can be screened for the disease during a regular Pap test. However, chlamydia is highly infectious. At least one-half of those who have contracted the disease will infect their partner(s) with it. Therefore, it is highly recommended that partners are tested and treated as well and that safe sexual practices are utilized in order to prevent contraction of this painful debilitating, disease. The younger populations of the province need to be educated about chlamydia, its effects, and routes of transmission in order to help reduce the spread of the disease.

Graph 28: New Notifications of Chlamydia (STD), Rates per 10,000 by Gender and Health Authority, 1998



Source: STD/AIDS Control, B.C. Centre for Disease Control Society
Population information provided by : B.C. STATS & B.C. Ministry of Finance & Corporate Relations
Data provided by: Health Data Warehouse, B.C. Ministry of Health
Prepared by: Women's Health Bureau, B.C. Ministry of Health

Potential Years Of Life Lost

The Potential Years of Life Lost Standardized Rates (PYLLSR) can be used as a health status indicator, as it examines the impact of premature death on years of life that have been lost due to disease and fatalities.

Unlike many other health status indicators, there is no clear regional pattern among the three mortality indicators (coronary heart disease, lung cancer, breast cancer) presented in this section. Northern, rural, and urban health regions are found at the high and low ends of the mortality rate ranges. There are many possible reasons for the variations between the health authorities on the mortality indicators. They include:

- effects of pollution, such as water and air contamination;
- demographics, such as age of the population of a particular area; and,
- socioeconomic factors, such as poverty, housing, nutrition, alcoholism, and smoking.

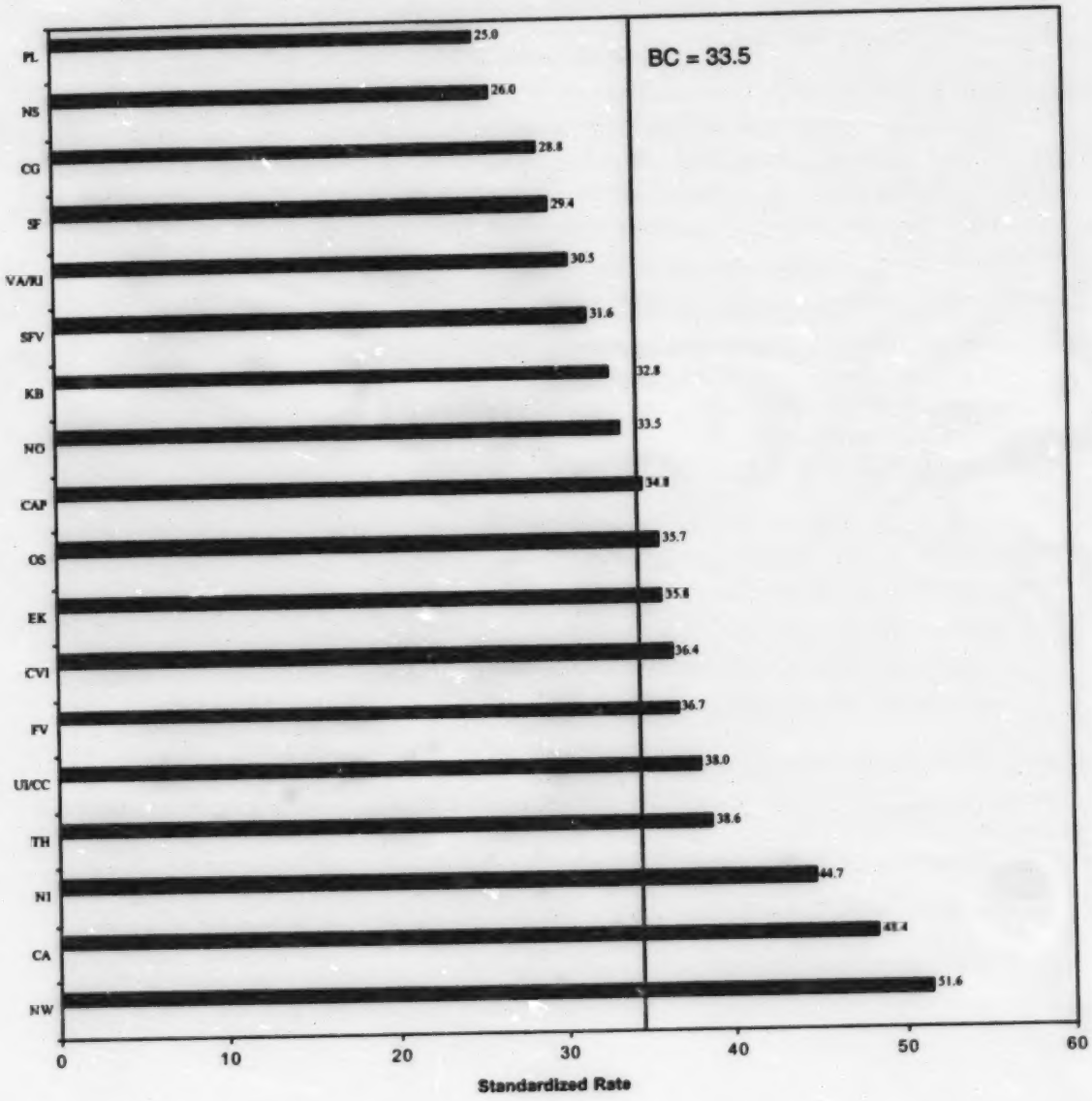
The reasons are not entirely clear for the variation among the health areas but may be related to a complex distribution of risk factors and treatment services throughout the health authorities of the province. Further research is needed in this area.

In addition to the negative impact deadly diseases cause on quality of life, the health care and workplace costs associated with the conditions are immense. It is recommended that health authorities and planners focus on prevention strategies that:

- reduce the prevalence of such conditions and therefore the associated treatment costs; and,
- reduce the negative impact on quality of life that results from such diseases.

Given the variation among health authorities on each of the mortality indicators, it is recommended that health authorities and planners also work towards investigating the reasons for the disparities.

Graph 29: Potential Years of Life Lost from All Causes of Death, Standardized Rates per 1,000 Standard Population for Females by Health Authority, 1999



Source: B.C. Vital Statistics Agency, B.C. Ministry of Health
Population information provided by: B.C. STATS & B.C. Ministry of Finance & Corporate Relations
Date provided by: Health Data Warehouse, BC Ministry of Health
Prepared by: Women's Health Bureau, B.C. Ministry of Health

CONCLUSION

The information presented in this profile reflects the current status of British Columbia's health care system with respect to women and their heath care needs.

Several important findings demonstrate that:

- although women have a longer life expectancy than men do, there is evidence that they are not enjoying a high quality of life throughout their lifetime;
- women are more likely than men to have lower incomes, experience poverty, be on income assistance, and be lone parents;
- most women experience a high level of reproductive health, although there is evidence that women in certain health authorities are unable to access the full range of reproductive health services. In addition, many women experience unintended pregnancies and sexually transmitted diseases. Many of these problems could be alleviated through education, preventive practices, early detection, and access to comprehensive reproductive and sexual health services;
- many women may be receiving unnecessary and inappropriate health care services, as shown by regional variations in cesarean sections and hysterectomies;
- women are more likely to experience violence at the hands of someone known to them; and,
- several populations of women experience unemployment, violence, poverty, barriers to the health care system, and lower education and quality of life than others. These include Aboriginal women, women with disabilities, senior women, adolescent girls, women from visible minority groups, and lesbians.

How women are valued in society has a direct impact on their health. Many women in B.C. "do not enjoy the same social status as men, as is shown by the fact that they receive less pay for the same work, are victims of violence, often live in poverty, and are under-represented in decision-making bodies"(*Provincial Health Officer's Annual Report* 1995, p. 180). Solutions to these problems require consideration of a wide variety of issues including: "how women are valued in our society, the social and economic conditions in which they live, the personal responsibility that women are able to take for their own health, lifestyle choices they are able to make, and their ability to access both preventive and treatment services" (*Provincial Health Officer's Annual Report* 1995, p. 180).

There is an on-going need to both collect and analyze data by gender in order to measure the health of women in B.C. It is also important to collect data on appropriate indicators about the health of women, who are marginalized, under-represented, or not currently identified in health data and information.

Women's health comprises much more than diseases and physical conditions. It involves emotional, social, cultural, spiritual, and physical well being and it is influenced by the social, political, and economic context of their lives. In order to meet the health needs of more than half the population of British Columbia, the health planning process must take steps to ensure that programs and services are accessible, appropriate, and sensitive to the unique health care needs of women and to the varied contexts of their lives.

APPENDIX A

Health Authority Abbreviations:

EK	East Kootenay
KB	Kootenay Boundary
NO	North Okanagan
OS	Okanagan Similkameen
TH	Thompson
FV	Fraser Valley
SFV	South Fraser (Valley)
SF	Simon Fraser
CG	Coast Garibaldi
CVI	Central Vancouver Island
UI	Upper Island/ Central Coast
CA	Cariboo
NW	North West
PL	Peace Liard
NI	Northern Interior
VA/RI	Vancouver/Richmond
NS	North Shore
CAP	Capital

References

1. Provincial Profile of Women's Health: A Statistical Overview of the Health Indicators for Women in British Columbia, Women's Health Bureau, Ministry of Health & Ministry Responsible for Seniors, May 1999.

2. Provincial Profile Of Women's Health: Updated Data on Selected Indicators, Women's Health Bureau, Ministry of Health & Ministry Responsible for Seniors, June 2000.

APPENDIX B

Female Aboriginal Population Expressed as a Percentage of the Total Female Population of British Columbia, 1999 Data

Health Authority	Other Female Population (BC)	Aboriginal Female Population	Female Aboriginal Population as a Percentage of the Total Female Population (BC)
NO	59,787	1,806	3.00%
OS	118,341	2,627	2.20%
TH	67,557	7050	10.40%
FV	119,995	4,874	4.10%
SFV	285,819	2,718	1.00%
SF	256,295	3,271	1.30%
CVI	122,669	8,248	6.70%
NI	64,761	6,193	9.60%
VA/RI	371,552	6,598	1.80%
NS	92,914	1,526	1.60%
CAP	173,635	3,996	2.30%
EK & KB	81,825	1,242	1.50%
CG	38,678	2,343	6.10%
UI/CC	60,435	4,926	8.20%
CA	37,421	4,006	10.70%
NW	43,883	12,411	28.30%
PL	32,180	2,473	7.70%
BC	**2,027,747**	**76,601**	**3.80%**

Source: B.C. Vital Statistics Agency, B.C. Ministry of Health
Prepared by: Women's Health Bureau, B.C. Ministry of Health